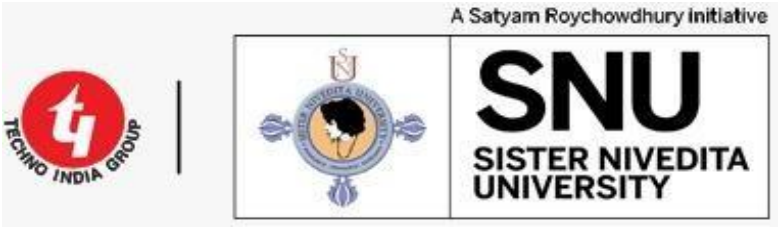

Hypersexual Behavior, Sexual Desire, and Disturbances in Self-Organization Among Individuals With PTSD, C-PTSD, and No Trauma History: A Comparative Study

This dissertation is submitted for the partial fulfilment of the degree of

M.Sc. in APPLIED PSYCHOLOGY (SPECIALIZATION IN CLINICAL PSYCHOLOGY

Work under the supervision of

ANINDITA MUKHERJEE

Head of the Department

Department of Psychology

Sister Nivedita University

Submitted by

PUJA MAJI

M.sc Student

Clinical Psychology

Department of Applied Psychology

Sister Nivedita University

A Satyam Roychowdhury Initiative

SNU
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CIRTIFICATE

This is to clarify that the dissertation entitled "Hypersexual Behavior, Sexual Desire, and Disturbances in Self-Organization Among Individuals With PTSD, C-PTSD, and No Trauma History: A Comparative Study" submitted by Miss Puja Maji, a 4th semester M.Sc. student in applied psychology (specialization in clinical psychology), Sister Nivedita University, is a bonafida work, which may be placed before the board of examiners for their evaluation. This is in partial fulfilment of the Degree of M.Sc in applied psychology (specialization in clinical psychology), Sister Nivedita University.

This is an original study done by the candidate and has not been submitted by her before in any form for any other degree of this university or any other university.

Partially supervised.
Anmukherjee.
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Anindita Mukherjee

Head of the Department

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Anindita Mukherjee

Head of the Department

Department of Applied Psychology

Sister Nivedita University

PLAGIARISM CERTIFICATE

"I, Puja Maji, hereby declare that the research work titled "Hypersexual Behavior, Sexual Desire, and Disturbances in Self-Organization Among Individuals With PTSD, C-PTSD, and No Trauma History: A Comparative Study", conducted by me, has been completed with full honesty and integrity. I confirm that the work is original and all sources of information have been appropriately acknowledged and cited. I affirm that the research work has undergone plagiarism checks to ensure its authenticity. I take full responsibility for the content and findings presented in this research."

Signature:

Name: Puja Maji

Enrollment ID: 2322230002008

Program and semester: M.Sc in Applied Psychology (Clinical Psychology Specialization).

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Acknowledgment

At this moment of accomplishment, I would like to express my gratitude to all those who helped me to complete this venture.

First and foremost, I would like to express my appreciation to my supervisor, **Anindita Mukherjee**, whose guidance helped shape the foundation of this dissertation. The intellectual direction, methodological framing she provided remained central to my approach.

Although navigating the final phases independently, without her direct review of the final draft, was undoubtedly challenging. However, this experience became a powerful lesson in academic self-discipline, resilience, and trust in my own scholarly voice. It allowed me to take ownership of my work in a way that has been both humbling and empowering.

I am deeply grateful to all the participants who generously shared their personal experiences and stories with me. Your willingness to trust me with such intimate and often painful aspects of your lives, despite the emotional challenges you carry, has been both humbling and profoundly moving. Your time, honesty, and courage formed the very heart of this research. This work would not exist without you, and I carry the weight and responsibility of your voices with deep respect.

A heartfelt thank you to Balai Daa (Balai Biswas), whose unwavering belief in me rekindled my journey back into academics. At a time when I had nearly given up on myself, it was your trust, encouragement, and loud strength that made me trust in myself. You pushed me to begin again, not just with studies, but with a sense of purpose, and that push has brought me to this moment. I carry deep gratitude in every step I take forward.

I am deeply grateful to all my friends, the life experiences, the silences, all the moments of distress or pain, each taught me lessons, my understanding of the world, and shaped me into the person I am. Those dark, gloomy hours that once seemed endless, in their own way, carved out the strength and empathy that I hold today.

To my parents, I owe a debt that words can hardly express. Your quiet sacrifices, unspoken yet unwavering support, even when I faltered, gave me the strength to continue when giving up seemed easier.

This dissertation stands not just as a culmination of research but as a testament to the many lives, lessons, and unseen kindnesses that carried me here.

For all of it, and all of you, I am deeply grateful.

30-4-25

~ Puja Maji

(Department of Psychology, Sister Nivedita University)

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~ Puja Maji

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ABSTRACT

Introduction: Trauma undeniably impacts psychological functioning, significantly influencing sexual behavior and self-organization. While the relationship between trauma and sexual behavior has garnered increasing scholarly attention, there is a striking lack of comparative research on hypersexual behavior, sexual desire, and disturbances in self-organization among individuals with PTSD, C-PTSD, and those without any trauma history. This study decisively addresses this critical gap in the literature.

Objectives: The study aimed to (1) systematically compare hypersexual behavior, sexual desire, and disruptions in self-organization among individuals with PTSD, complex PTSD (CPTSD), and those without a history of trauma, and (2) clarify the psychological mechanisms that connect trauma symptoms to dysregulated sexual behaviors..

Methodology: A purposive sample of 40 participants was recruited and categorized into PTSD, C-PTSD, and control groups based on symptomatology assessed through the International Trauma Questionnaire (ITQ; Cloitre et al., 2018). The Hypersexual Behavior Inventory (Reid et al., 2011) and the Sexual Desire Inventory (Spector et al., 1996) were utilized to assess sexual behavior and desire. Data were analyzed using Jamovi software, with Kruskal wallis test.

Results: Significant group differences emerged across all measured domains. Individuals with C-PTSD exhibited the highest levels of disturbances in self-organization and impairments, PTSD symptoms, and impairment, and impairment in in sexual behavior. Both PTSD and CPTSD groups demonstrated elevated hypersexual behavior compared to controls (without trauma history). Variations in sexual desire were observed, indicating trauma-associated dysregulation in sexual functioning.

Conclusion: The findings affirm that trauma, particularly in its complex form, and severity in symptomatology and impairment significantly disrupts sexual regulation and self-organization processes. These results underscore the necessity for a trauma-informed therapeutic process that simultaneously addresses sexual dysregulation, self-concept disturbances, particularly in complex trauma cases, to provide a holistic and targeted treatment approach

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INTRODUCTION

"Hypersexual Behavior, Sexual Desire, and Disturbances in Self-Organization Among Individuals With PTSD, C-PTSD, and No Trauma History: A Comparative Study"

INTRODUCTION

"Some stories live in the body." ~Melissa Febos

Trauma leaves no part of the human experience untouched. It fractures time, ruptures the narrative continuity of the self, and lingers in memory, body, desire, and silence. While the psychological consequences of trauma, such as posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD), are well-established in clinical literature, their reverberations into the domain of sexuality remain comparatively underexplored and insufficiently understood. Yet survivors often report profound shifts in their sexual functioning, ranging from compulsive sexual engagement to complete withdrawal. These behavioral manifestations, referred to as hypersexuality and hyposexuality, are not merely side effects but integral reflections of how trauma reshapes the psyche and its relational landscape.

Sexual behavior is often viewed as a deeply private aspect of our lives, is profoundly social and neurologically embedded. When someone experiences trauma, it can disrupt their relationship with sexuality in significant ways. It might become a space where powerlessness is reenacted or where individuals seek to numb their feelings, avoid intimacy, or overcompensate in other ways. For some, hypersexual behavior emerges as a way to reclaim a sense of agency or to seek validation, while others may respond with hyposexuality, which often reflects feelings of dissociation, shame, guilt, or a protective withdrawal from connection.

These two seemingly opposite responses share a common thread: they both represent an earnest, albeit complex, attempt to cope with the chaos and disorganization left by trauma. For survivors, disconnecting from desire can lead to hyposexuality, while others may find themselves overly engaged in sexual behaviors as a means of coping, resulting in hypersexuality. These behaviors are not mere responses to impulses; they are deep, psychic negotiations- efforts to make sense of the chaos that trauma introduces into their lives, reclaim control, or find some comfort in sensation. When we approach sexual behaviors through a trauma-informed lens, sexual behaviors become narrative artifacts of survival.

As Freud linked sexual dysfunction to unconscious conflict, behaviorists later emphasized the role of conditioned fear in sexual avoidance. However, it was Herman's (1992) revolutionary reframing of post-traumatic stress as a disorder of self-organization, rather than a mere collection of fear responses, that marked a pivotal moment in the field's recognition of trauma's profound impact on identity, emotions, and relationships. This paradigm shifts seamlessly aligned with Porges's (2003) Polyvagal Theory, which revealed how dysregulation of autonomic pathways propels survivors into states of hyperarousal, resulting in compulsive sexual behavior, or leads to dorsal-vagal shutdown, causing significant reductions in sexual desire.

In this study, we will thoroughly examine six interconnected variables: hypersexual behavior, sexual desire, PTSD symptoms, PTSD-related impairment, disturbances in self-organization (DSO), and DSO impairment. Each of these variables reflects a distinct aspect of the multifaceted legacy of trauma.

At the core of trauma's psychological impact are PTSD symptoms, which may manifest as intrusive flashbacks, hypervigilance, and various forms of behavioral avoidance. These symptoms are often accompanied by functional impairments that can undermine an individual's capacity to engage successfully in work, maintain interpersonal relationships, and perform selfcare activities. Herman's (1992) conceptualization of Complex PTSD situates these symptoms alongside disturbances in self-organization, including affective dysregulation, negative selfconcept, and relational difficulties. This creates a multidimensional syndrome frequently broader and more pervasive than classic PTSD alone. Empirical validation by Cloitre et al. (2013) outlined various DSO dimensions, demonstrating their predictive capacity regarding increased chronicity and overall impairment.

It is an event or series of events so overwhelming that they leave the individual psychologically fragmented, disrupting the delicate equilibrium between mind, body, and identity, to emotional, physical, psychological, and even intergenerational-shaping not only the individuals who endure it but also the societies and cultures that surround them.

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), trauma is typically defined as exposure to actual or threatened death, serious injury, or sexual violence. This exposure can occur in several ways:

- Direct Experience - experiencing a traumatic event firsthand.
- Witnessing - seeing a traumatic event happen to others.
- Learning - finding out that a close family member or friend has experienced trauma.
- Repeated or extreme exposure - being exposed to aversive details of traumatic events, such as first responders might be.

Scholars like Judith Herman (1992) and Bessel van der Kolk (2014) have further expanded our understanding of trauma, explaining that it goes beyond isolated events to include chronic or cumulative exposures, often referred to as "complex trauma." This type of trauma can gradually undermine an individual's emotional resilience and cognitive clarity.

In contrast, the ICD-11 (World Health Organization, 2018) offers a different perspective on PTSD, identifying three core symptom clusters:

1. Re-experiencing the Trauma - such as through flashbacks or nightmares.
2. Avoidance of Trauma-Related Stimuli- which includes avoiding thoughts, emotions, or external reminders related to the trauma.
3. Heightened Threat Perception - manifested as hypervigilance and an exaggerated startle response.

These criteria highlight underlying disturbances in memory processing, emotional regulation, and the body's stress-response systems. Furthermore, the ICD-11 introduces Complex PTSD (CPTSD), a diagnosis that acknowledges prolonged exposure to interpersonal trauma, such as childhood abuse or domestic violence. CPTSD expands upon the PTSD diagnosis by including additional symptoms like emotional dysregulation, negative self-concept, and difficulties in interpersonal relationships (Cloitre et al., 2019). This differentiation reflects a growing recognition of the unique and long-term effects of chronic trauma.

Explaining the biological mechanisms of trauma shows a mechanism of the nervous system that adapts rapidly and can also undergo long-term structural modifications at the brain level. The hypothalamic-pituitary-adrenal (HPA) axis orchestrates the body's initial response to traumatic events, resulting in the release of stress hormones, including cortisol and adrenaline. Such hormones prime the organism to a fight or flight response an evolutionary mechanism for survival that has persisted for millennia (McEwen, 2007). But when this system is triggered chronically or stays dysregulated over time, it can have damaging effects on brain structures.

For example, studies have repeatedly indicated that chronic trauma can lead to a shrinkage in the volume of the Hippocampus (The Memory Keeper): The hippocampus is responsible for memory processing. Trauma disrupts its functioning, resulting in fragmented, disordered recollections of traumatic incidents. Rather than being encoded as a cohesive narrative, traumatic memories appear as sensory fragments- sights, sounds, and bodily sensations—that feel as if they are happening in the present moment.

The Amygdala (The Alarm System): The amygdala, an essential almond-shaped structure in the brain, is the body's primary threat detection system that activates the fight-or-flight response. For trauma survivors, the amygdala often becomes hyperactive, responding to perceived threats even in safe environments. This hyperreactivity explains why innocuous stimuli, such as smells, sounds, or facial expressions, can trigger overwhelming fear responses (van der kolk,2014).

The Prefrontal Cortex (The Rational Brain): The prefrontal cortex governs reasoning and impulse control, playing a critical role in emotional regulation. In cases of trauma, its functionality is frequently compromised, resulting in impulsivity, emotional dysregulation, and a distorted ability to distinguish real threats from imagined ones (Shin et al., 2006).

Van der Kolk's insightful assertion in his book "The Body Keeps the Score" powerfully highlights that our physical tissues are witnesses to the wounds inflicted by trauma.

Van der Kolk's statement rings true: unprocessed trauma is stored in the muscles, nervous system, and visceral organs, driving continual stress responses. Individuals may experience hyperarousal characterized by ever presented state of alertness, increased heart rate, muscle tension, sleep disturbances. A constant state of heightened vigilance in the body is not without consequences. It leads to fatigue, gastrointestinal problems, and weakened immune system.

Behavioral Effects:

- Hypersexuality or Hyposexuality: Trauma, particularly of a sexual nature, can lead to dysregulated sexual behaviors-whether through compulsivity (hypersexuality) or aversion (hyposexuality), as survivors attempt to reclaim control or defend against further harm (Courtois & Ford, 2013).

- Addiction and Self-Destructive Behaviors: A significant number of trauma survivors turn to substance abuse, self-harm, or reckless behaviors as futile attempts to numb their emotional pain.

Traumagenic Dynamics Model explains that child sexual abuse creates five core dynamics—traumatic sexualization, betrayal, stigmatization, powerlessness, and traumatic sexual scripts—that together shape survivors' sexual development. Traumatic sexualization refers to the process by which sexuality is inappropriately shaped by the abuse, leading to distorted associations between sexual activity and emotional regulation. Betrayal and stigmatization foster deep mistrust and shame, which can drive both compulsive sexual behaviors (as attempts to regain control or alleviate shame) and sexual avoidance (to escape reminders of trauma). Powerlessness entrenches a lack of agency, often manifesting as passivity or hypervigilance in intimate contexts. Finally, the internalized traumatic sexual scripts can result in hypersexuality, driven by compulsive enactment, or hyposexuality, characterized by emotional withdrawal from sexual experiences. This model thus accounts for the polarized sexual behaviors and extreme skewness (Finkelhor & Browne, 1985).

Dopamine, the neurotransmitter associated with pleasure, reward, and motivation, is hyperactivated in individuals with compulsive sexual behavior, paralleling patterns observed in "substance addictions (Voon et al., 2014).

- Over time, repeated exposure to sexual gratification leads to neural sensitization, resulting in increased craving and diminished inhibitory control (Kraus et al., 2016).

Prefrontal cortex dysfunction and impulse control deficits : The prefrontal cortex (PFC) governs executive functions, including decision-making, impulse control, and emotional regulation. Dysfunction in this area directly contributes to difficulty managing sexual urges, resulting in compulsive behavior. Consequently, individuals with hypersexual behavior often exhibit deficits in impulse control, exacerbating the persistence of their symptoms.

Hypersexual behavior often serves as a maladaptive strategy for emotional regulation, offering temporary relief from the distress caused by intrusive memories and heightened sensory awareness, common in trauma survivors. Freud's concept of Repetition Compulsion is especially relevant in this context. He observed that individuals who experienced early trauma often unconsciously seek to recreate aspects of the traumatic event, not for pleasure, but as an

attempt to gain mastery over it (Freud, 1920/1955). In the realm of sexuality, this may mean reenacting dynamics of control, helplessness, or violation that mirror those of the original trauma.

According to Gross's (1998) model of emotion regulation, individuals with limited access to adaptive coping strategies may resort to high-arousal behaviors, such as compulsive sexual activity, as a means to manage overwhelming, distressing feelings. The Self-medication hypothesis posited by Khantzian (1997) further supports this notion, suggesting that various behaviors, including sexual activity, serve as mechanisms to numb or escape from intense psychological pain when the body's natural regulatory systems are overwhelmed.

Conversely, "sexual desire" can diminish into profound hyposexuality when avoidance mechanisms become the predominant strategy for survival in the aftermath of trauma. Attachment Theory, articulated by Bowlby (1969) and expanded upon by Bartholomew & Horowitz (1991), provides insight into how early betrayals or neglect from caregivers can lead to insecure internal working models for relationships. For example, individuals with an anxious attachment style may oscillate between desperate attempts to seek intimacy and subsequent fearful withdrawal, while avoidantly attached individuals often create emotional distance from sexual closeness altogether.

Object relations theory further deepens our understanding by examining how early relationships shape internal representations of self and others. In cases of developmental trauma, especially abuse or emotional neglect, the child may internalize a fragmented sense of self and others—idealized or devalued, loving or abusive, nurturing or abandoning (Fairbairn, 1952).

Heiman's cognitive-behavioral approach emphasizes how maladaptive beliefs (e.g., "sex is dangerous" or "I must earn affection through sex") and automatic thoughts, often instilled by trauma, drive sexual dysfunction. Negative schemas about one's body and worth can lead to avoidance (hyposexuality), while "compensatory" schemas—believing sex will restore value—can drive compulsivity (hypersexuality). Such cognitive patterns help explain the control and PTSD groups' skewed distributions: those with ingrained negative beliefs avoid sex, clustering at low scores, while others engage compulsively, stretching the upper tail of the distribution (Heiman, 1977).

This is how trauma reshapes our core aspects of identity, affect regulation, and relational capacity. These DSO dimensions amplify PTSD related impairment and shape sexual behaviour in a complex, often paradoxical way.

This study aims to explore the interrelations between hypersexual behavior, sexual desire, PTSD, and disturbances in self-organization across three distinct groups: individuals with CPTSD, PTSD, and no trauma history. Existing literature often isolates either hypersexual or hyposexual behavior, but this research investigates both extremes along with their underlying emotional and biological drivers.

By weaving together Polyvagal Theory, emotion regulation, self-medication, attachment theory, traumagenic dynamics, and particularly disturbances in self-organization, this study offers a nuanced understanding of how trauma reshapes core aspects of identity, affect regulation, and sexual functioning. Importantly, it fills a critical gap in trauma literature by examining trauma-related symptomatology and behavioural manifestations both hyper- and hyposexual outcomes, in relation to trauma severity and DSO. In doing so, the research moves closer to trauma-informed models of care that honor the complex, often paradoxical ways trauma bearer's lives.

Ultimately, this research is driven by the need for a holistic and integrative understanding of trauma's aftermath - one that moves beyond pathology alone to encompass behavioral, emotional, and relational dimensions of human functioning.

LITERATURE REVIEW

LITERATURE REVIEW

A literature review, as defined by A.K. Singh in Tests, Measurements, and Research Methods in Behavioural Sciences, is a comprehensive and systematic examination of existing research, theories, and findings relevant to a specific topic. It involves identifying, analysing, and synthesizing previous studies to understand the current state of knowledge, highlight gaps, and establish the foundation for new research. Singh emphasizes that a literature review is not just a summary but a critical evaluation that helps contextualize research questions, refine methodologies, and justify the need for further study.

Sexual behavior and trauma-related disorders have long been a subject of psychological interest due to their deeply rooted implications on emotional regulation, interpersonal relationships, and identity formation. Recent diagnostic criteria, those in ICD-11 and DSM-5, have emphasized PTSD and Complex PTSD, especially regarding behavioral dysregulation, including hypersexuality and diminished sexual desire.

Based on my topic, "Hypersexual behavior, Sexual desire, and Disturbances in selforganization among individuals with PTSD, C-PTSD, and No Trauma History: A comparative Study," this literature review systematically examines previous empirical studies, the theoretical framework, and recent research to understand how trauma-related disorders are associated with hypersexuality, hyposexuality, and identity disturbances.

In a research titled "Traumatic experience and psychosomatic disease: In his seminal paper, Pennebaker (1985) explores the psychological and physiological consequences of traumatic experiences, focusing particularly on how behavioral inhibition, obsessive thought patterns, and confiding influence the development of psychosomatic disease. Rather than centering solely on the trauma itself, Pennebaker argues that the suppression of trauma-related thoughts and emotions, termed behavioral inhibition, can lead to chronic stress responses, such as heightened autonomic nervous system activity and weakened immune function, which in turn increase susceptibility to various psychosomatic illnesses. Drawing from a range of clinical and experimental studies involving both clinical populations and non-clinical samples like college students, the paper outlines a conceptual framework in which the failure to express traumatic experiences fosters obsession (recurrent intrusive thoughts) and physiological strain. Crucially, Pennebaker emphasizes the therapeutic value of disclosure, asserting that individuals who confide in others through speaking or writing exhibit improved health outcomes, including reduced doctor visits and enhanced immune markers. The act of confiding helps reduce the psychological burden of inhibition, promotes cognitive and emotional processing, and alleviates the harmful effects of internalized stress. Although the paper is largely theoretical, it synthesizes existing empirical research to support the claim that expressive behavior plays a critical role in mitigating the negative health impacts of trauma. Pennebaker's work significantly contributed to the development of expressive writing interventions and advanced the understanding of the interplay between emotional expression and physical health, making it a foundational text in health psychology and psychosomatic medicine (Pennebaker, J. W., 1985).

In "The Traumatic Impact of child sexual abuse: A Conceptualization, introduced the "traumagenic dynamics." This paper has tried to suggest a framework for a more systematic understanding of the effects of sexual abuse. It has introduced four traumagenic dynamics,

which are seen as the four links between the experience of sexual abuse and the sequelae that have been widely noted. Four traumagenic dynamics – traumatic sexualization, betrayal, stigmatization, and powerlessness – are identified as the core of the psychological injury inflicted by abuse. These dynamics can be used to make assessments of victimized children and to anticipate problems to which these children may be vulnerable subsequently (Finkelhor and Browne (1985).

In a cross-sectional, observational study, titled "Physical and sexual abuse in childhood: Relationship with post-traumatic stress disorder," utilized structured interviews and record analyses to examine the association between childhood physical and sexual abuse and posttraumatic stress disorder diagnoses in a sample of psychiatrically hospitalized children and adolescents. Key variables included types of childhood abuse (physical and sexual) and the presence of PTSD symptoms. The study sample consisted of 100 psychiatrically hospitalized individuals aged 6 to 17 years. Results indicated that children with a documented history of physical or sexual abuse were significantly more likely to be diagnosed with PTSD compared to non-abused children. Additionally, sexual abuse was found to be more strongly associated with PTSD symptoms than physical abuse. (Kiser et al., (1991).

In a research titled, "Vulnerability to posttraumatic stress disorder in adult offspring of Holocaust survivors," a critical investigation was conducted into the vulnerability to posttraumatic stress disorder (PTSD) among adult children of Holocaust survivors. The study's primary objective was to establish that parental PTSD, rather than mere exposure to holocaust trauma, significantly heightens the risk of PTSD in their children.

The research involved 78 adult participants, meticulously divided into three groups: offspring of Holocaust survivors with PTSD (n = 26), offspring of Holocaust survivors without PTSD (n = 26), and a control group with no Holocaust survivor background (n = 26). Key variables focused on the PTSD diagnosis of the parents and the severity of PTSD symptoms experienced by the offspring.

The methodology deployed structured clinical interviews and rigorous psychological assessments, including the Clinician-Administered PTSD Scale (CAPS) for PTSD symptoms, the Structured Clinical Interview for DSM-IV (SCID) for psychiatric diagnoses, the Symptom Checklist-90-Revised (SCL-90-R) for general psychological distress, and the Dissociative Experiences Scale (DES) for dissociative symptoms.

Results unequivocally demonstrated that adult offspring of Holocaust survivors with PTSD were significantly more likely to display PTSD symptoms compared to both those whose parents did not have PTSD and the control group. These findings incontrovertibly indicate that parental PTSD, rather than exposure to trauma alone, increases the vulnerability to PTSD in the next generation. (Yehuda et al., 1998).

In a study titled "The revictimization of child sexual abuse survivors: An examination of the adjustment of college women with child sexual abuse, adult sexual assault, and adult physical abuse. Child Maltreatment" aimed to explore the psychological adjustment of college women who had encountered childhood sexual abuse (CSA) and experienced revictimization through adult sexual assault or physical abuse. The primary objective was to understand how different

victimization histories can influence mental health outcomes, such as depression, anxiety, dissociation, and self-esteem.

In this research, 374 undergraduate women from a university participated by completing selfreport questionnaires regarding their histories of abuse and their current psychological functioning. The key variables examined included experiences of CSA, adult sexual assault, and adult physical abuse, alongside levels of depression, anxiety, dissociation, and self-esteem. The study utilized several psychological assessments, such as the Beck Depression Inventory (BDI) for measuring depression, the State-Trait Anxiety Inventory (STAI) for anxiety, the Tennessee Self-Concept Scale for self-esteem, and the Dissociative Experiences Scale (DES) for assessing dissociative symptoms.

The analysis compared women with single instances of victimization to those with multiple experiences. Findings revealed that women who had both experienced CSA and faced revictimization in adulthood reported the most significant psychological challenges, displaying higher levels of depression, anxiety, and dissociation, along with lower self-esteem. These results emphasize the critical need to address the cumulative impact of repeated interpersonal trauma throughout various developmental stages and highlight the importance of providing comprehensive support for those affected (Messman-Moore et al., 2000).

In a research titled "Attachment styles and male sex addiction", examined the relationship between adult attachment styles and sex addiction among men. The primary research objective was to determine whether specific insecure attachment patterns—such as anxious or avoidant attachment—were associated with higher levels of sexual addiction symptoms. The study included 212 adult men, with participants recruited through sex addiction support groups, treatment facilities, and community postings. Key variables included adult attachment style (independent variable) and severity of sex addiction symptoms (dependent variable). Participants completed several standardized measures, including the Relationship Styles Questionnaire (RSQ) to assess adult attachment styles and the Sexual Addiction Screening Test (SAST) to evaluate symptoms of sexual addiction. Data analysis focused on comparing attachment patterns among men with higher versus lower scores on sexual addiction symptoms. Results indicated that men with sex addiction symptoms were significantly more likely to report insecure attachment styles, anxious $F(1, 38) = 6.122$, $p < .05$ and avoidance $F(1, 37) = 4.685$, $p < .05$ compared to men with lower levels of symptoms. These findings suggest that difficulties in emotional attachment and intimacy may be important underlying factors contributing to the development and maintenance of sex addiction in men (Zapf et al., 2008).

The research titled "Emotional and interpersonal correlates of hypersexuality: Personality, attachment, and emotion regulation" provides valuable insights into the emotional and interpersonal factors linked to hypersexuality, emphasizing the important roles of personality traits, attachment styles, and emotion regulation. Included 190 participants, comprising both men and women, recruited from a university setting. The researchers utilized several standardized instruments to assess various psychological constructs: Hypersexual Behavior Inventory (HBI): to measure hypersexuality symptoms. NEO Five-Factor Inventory (NEOFFI): to evaluate personality traits, including neuroticism, extraversion, openness, agreeableness, and conscientiousness. Experiences in Close Relationships-Revised (ECR-R): to assess adult attachment styles, focusing on anxiety and avoidance dimensions. Difficulties in Emotion Regulation Scale (DERS): to measure challenges in emotion regulation. They characterize hypersexuality not just as an increase in sexual activity, but as a behavior pattern influenced by

deeper psychological processes. The findings suggest a constructive perspective: individuals with higher levels of hypersexuality often exhibit greater neuroticism and challenges in emotional regulation. This indicates that hypersexual behaviors may serve as maladaptive coping mechanisms for managing emotional distress. Additionally, the study highlights that attachment anxiety can significantly predict hypersexual tendencies, pointing to the idea that difficulties in forming secure interpersonal bonds might contribute to these behaviors (Hall et al., 2012).

In the study titled "The Role of Emotion Dysregulation in the Association Between PTSD and Sexual Risk Behavior Among Substance-Dependent Inpatients," researchers Weiss, Tull, Lavender, and Gratz examined how difficulties in regulating emotions can clarify the connection between PTSD and sexual risk behaviors in individuals receiving treatment for substance dependence. Their findings reveal that greater severity of PTSD symptoms is associated with an increase in sexual risk behaviors. Notably, this relationship is significantly influenced by emotion dysregulation, particularly impulsivity and challenges in accessing effective emotion regulation strategies.

These insights suggest that trauma-related sexual risk behaviors may serve as maladaptive coping mechanisms for managing intense emotional states. The research highlights a valuable opportunity for developing interventions that focus on enhancing emotion regulation skills, which could help reduce high-risk sexual behaviors in trauma-exposed and substancedependent populations. By integrating emotional and behavioral health into trauma-informed care approaches, we can foster more effective support for individuals facing these challenges (Weiss et al., 2013).

In the book, “Compulsive cybersex: The new tea room. In Cybersex: The Dark Side of the Force,” Cybersex has become the new tea room for meeting anonymous partners and engaging in a fantasy world in which survivors of childhood abuse escape the demands of daily life as well as the pain and shame of past trauma. Compulsive cybersex was described as a survival mechanism involving dissociative reenactment and affect regulation. Compulsive cybersex represents a courtship disorder in which the" high" of being wanted by someone for sex regulates affect and bolsters a fragile self. The fantasy world of cybersex is a dissociative experience in which a person escapes the demands of daily life, as well as the pain and shame of past trauma (Schwartz et al., 2013).

In a research titled “An examination of risky sexual behavior and HIV in victims of child abuse and neglect: 30-year follow-up,” This article examined links between childhood maltreatment and risky sexual behavior (early sexual contact, promiscuity, prostitution) and HIV in adulthood. Using a prospective cohort design, physically and sexually abused and neglected children (ages 0–11) with documented cases during 1967–1971 were matched with nonmaltreated children and followed into adulthood. Early sexual contact, promiscuity, and prostitution were assessed through in-person interviews and official records (prostitution) at approximately age 29 (N= 1196). HIV tests were conducted at an approximate age of 41 (N= 631). Child maltreatment was associated with prostitution (OR= 2.47, 95% CI= 1.35–4.50) and early sexual contact (OR= 1.73, 95% CI= 1.24–2.40). Prevalence of HIV in the abuse/neglect group was twice that in controls (OR= 2.35, 95% CI=. 64–8.62), although this difference did not reach conventional levels of statistical significance. These findings provide prospective evidence that maltreated children are more likely to report sexual contact before age 15, engage

in prostitution by young adulthood, and test positive for HIV in middle adulthood (Wilson & Widom, 2014).

In a research on "Disinhibited Exposing Behavior, Hypersexuality, and Erectile Dysfunction as a Consequence of Posttraumatic Stress in a 42-Year-Old Male Patient,". In this report, the case of a 42-year-old male with severe posttraumatic stress symptoms who displayed apparent exhibitionistic behavior, hypersexual behavior in the form of excessive masturbation, and erectile dysfunction is presented. Differential diagnostics showed that the presented exhibitionistic behavior could be more accurately classified as non-paraphilic disinhibited exposing behavior. Functional behavioral analysis of his sexual behavior suggested that disinhibited exposing and hypersexual behavior served as dysfunctional coping strategies for trauma-associated negative emotions. Erectile dysfunction seemed to be the result of traumaassociated hyperarousal and excessive masturbation. Within the context of operant learning processes, the research proposes that his sexual behaviors became highly automated and were used as the main strategies to regulate trauma-associated negative emotions (Petri-Kelvasa et al., 2017).

In a research titled "Sexual Functioning After Childhood Abuse: The Influence of PostTraumatic Stress Disorder and Trauma Exposure," impairments in sexual functioning and sexual satisfaction are very common in women who have experienced childhood sexual abuse (CSA). The aim of this study was to investigate the influence of sexual trauma exposure and PTSD on sexual functioning and sexual satisfaction by comparing 3 groups of women.

Women with PTSD after CSA (N = 32), women with a history of CSA and/or physical abuse but without PTSD (trauma controls [TC]; N = 32), and healthy women (N = 32) were compared concerning self-reported sexual functioning and sexual satisfaction. Trauma exposure was assessed with the Childhood Trauma Questionnaire, and PTSD was assessed with the Clinician-Administered PTSD Scale for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

Sexual functioning was assessed with the Sexual Experience and Behavior Questionnaire, and sexual satisfaction was assessed with the questionnaire Resources in Sexuality and Relationship. And the results show that PTSD patients had significantly lower sexual functioning in some aspects of sexual experience (sexual aversion, sexual pain, and sexual satisfaction) but did not significantly differ in sexual arousal and orgasm from the other 2 groups. TC and healthy women did not significantly differ from each other on the measures of sexual functioning or sexual satisfaction. Results suggest that the development of PTSD has a greater impact on sexual functioning than does the experience of a traumatic event.

The findings suggest that the experience of sexual abuse does not necessarily lead to sexual impairment, whereas comparably low levels of sexual functioning seem to be prominent in PTSD patients after CSA (Bornefeld et al.,2018).

A study called "Interpersonal Violence, Early Life Adversity, and Suicidal Behavior in Hypersexual Men" investigated the relationships among early life adversity (ELA), adult interpersonal violence, and suicidal behavior in hypersexual men. The study used a clinical sample of 67 adult men diagnosed with hypersexual disorder, recruited from a Swedish outpatient clinic. Key variables included early life adversity, assessed via the Childhood

Trauma Questionnaire-Short Form (CTQ-SF); interpersonal violence, measured with the Karolinska Interpersonal Violence Scale (KIVS); and suicidal behavior, operationalized as a lifetime history of suicide attempts. Additional measures included the Montgomery-Åsberg Depression Rating Scale (for depression severity), the Barratt Impulsiveness Scale (for impulsivity), serum testosterone levels, and structured clinical interviews for psychiatric comorbidities. The study found that 25% of participants had attempted suicide, and those individuals had significantly higher rates of childhood emotional and sexual abuse, as well as adult victimization through interpersonal violence. Elevated depression and impulsivity scores were also noted among suicide attempters, while testosterone levels did not differ significantly. These findings underscore the importance of trauma-informed approaches in assessing and treating men with hypersexual behavior, especially given the strong link between cumulative trauma exposure and suicidality (Chatzittofis et al., 2017).

In the study titled "The Association Between Sexual Dysfunction, Complex PTSD, and Disturbances in Self-Organization: A Network Analysis," the researchers explored the intricate relationships between sexual dysfunction and the symptom clusters of Complex Posttraumatic Stress Disorder (CPTSD), with a particular focus on disturbances in self-organization (DSO). Utilizing a network analytical approach, the study aimed to identify how symptoms of sexual dysfunction are interconnected with CPTSD and DSO symptoms. The sample comprised 445 inpatients diagnosed with PTSD following childhood sexual abuse. The findings revealed that difficulties in sexual functioning were highly prevalent among the participants, with significant associations identified between sexual dysfunction and symptoms of depression, hyperarousal, anger, and dissociation. Notably, certain symptoms, such as dissociative amnesia and depressed mood, emerged as central nodes within the network, indicating their pivotal role in the interplay between CPTSD and sexual dysfunction. The study underscores the importance of addressing sexual health in the treatment of CPTSD, particularly in individuals with a history of childhood sexual abuse (Knefel et al., 2020).

In a research titled “Women's Sexual Desire, Trauma Exposure, and Posttraumatic Stress Disorder. Journal of traumatic stress” suggests that posttraumatic stress disorder (PTSD) is associated with sexual dysfunction; however, there is a paucity of research examining the relations among trauma exposure, PTSD, and low sexual desire, specifically. Thus, the goal of the present study was to investigate whether women with hypoactive sexual desire disorder (HSDD; n = 132) were more likely to meet the criteria for a diagnosis of current or lifetime PTSD relative to women with no sexual desire concerns (n = 137). They compare the type, frequency, and intensity of PTSD symptoms between the two groups. Finally, examined whether women in the two groups were exposed to more or different types of potentially traumatic events. Compared to women with no sexual health concerns, women with HSDD were more likely to meet the criteria for current PTSD, odds ratio (OR) = 5.50, 95% CI [1.18, 25.61]; and lifetime PTSD, OR = 2.78, 95% CI [1.56, 4.94]. Women in the HSDD group also had higher odds of meeting criteria for avoidance (5.10 times) and hyperarousal symptoms (4.48 times) and scored higher on measures of past-month PTSD symptom frequency, d = 0.62, and intensity, d = 0.57. No group differences were observed regarding reexperiencing symptoms, the associated features of PTSD, or the type or frequency of exposure to potentially traumatic events. The findings indicate PTSD symptomatology may be a predisposing or perpetuating contributor to low sexual desire, and low sexual desire and PTSD may be related through an alteration in stress adaptability (O'Loughlin et al.,2020).

In the study titled "Compulsive Sexual Behavior and Dysregulation of Emotion" by LewStarowicz et al. (2020), the authors conducted a comprehensive literature review to explore the relationship between compulsive sexual behavior (CSB) and dysregulation of emotion (DE). The review synthesized findings from various studies, utilizing databases such as EBSCO, PubMed, and Google Scholar. The researchers examined patterns of DE as a common clinical feature in individuals with CSB, identifying DE as a core element of a failure to cope with sexual impulses, thoughts, urges, or resulting in uncontrolled sexual behaviors. The study highlighted that DE may contribute to the occurrence of CSB, with sexual arousal, albeit maladaptive way of coping with negative mood states. Additionally, the review discussed the role of childhood sexual abuse and insecure attachment patterns as potential risk factors for CSB, likely mediated by DE. The authors also noted that DE is positively associated with CSB symptom severity and emphasized the need for psychological and pharmacological interventions targeting emotional regulation in the treatment of CSB (Lew-Starowicz et al., 2020).

In research titled "Hypersexuality as a Maladaptive Coping Mechanism in Trauma Survivors: The Roles of Depression and Guilt" by Giuseppin et al. (2020), the authors examined how hypersexuality functions as a coping mechanism for individuals with a history of trauma, focusing on the mediating roles of depression and guilt. The study utilized a sample of 521 participants (74.9% female, 25.1% male; mean age 26.46 years) who completed a psychometric protocol including the Hypersexual Behavior Inventory (HBI), the Defense Mechanisms Rating Scale, and the Brief Symptom Inventory. There was a statistically significant direct effect of post-traumatic symptoms (ITQTotal) on hypersexual behavior (HBTotal). Furthermore, indirect effects were also statistically significant, providing support to the hypothesis that depression and guilt would be serial mediators of trauma-hypersexual behavior relations. The paths through depression and guilt have been found to be the most significant, with moderate and high indirect effects on hypersexuality. Moreover, male gender, as a covariate variable, is a relevant risk factor for hypersexual behavior (Giuseppin et al., 2020).

In the study titled "Does Sexual Desire Improve with Posttraumatic Stress Disorder Treatment in Older Veterans?" the authors investigated whether successful treatment of posttraumatic stress disorder (PTSD) leads to improvements in sexual desire among older veterans. The research involved a sample of 187 veterans with PTSD who underwent prolonged exposure therapy at two outpatient PTSD specialty clinics. The study utilized standardized assessments, including the PTSD Checklist – Military Version (PCL-M) to measure PTSD symptoms and item 21 of the Beck Depression Inventory – Second Edition (BDI-II) to assess sexual desire. The findings indicated that veterans who responded positively to PTSD treatment reported improvements in sexual desire throughout therapy. However, this effect was influenced by the severity of depression at the start of treatment, suggesting that addressing co-occurring depressive symptoms is crucial for enhancing sexual desire outcomes in this population (Badour et al., 2020).

In the research titled "Hypersexuality and Trauma: A Mediation and Moderation Model from Psychopathology to Problematic Sexual Behavior," the study investigated the role of trauma, specifically PTSD, depression, shame, and guilt, in hypersexual behavior. Utilizing a sample of 1,025 participants, the researchers employed instruments such as the Hypersexual Behavior Inventory (HBI), International Trauma Questionnaire (ITQ), Patient Health Questionnaire

(PHQ-9), and the State Shame and Guilt Scale (SSGS). The mediation/moderation model was preferred for data analysis.

There was a statistically significant direct effect of post-traumatic symptoms (ITQTotal) on hypersexual behavior (HBTotal). Furthermore, indirect effects were also statistically significant, providing support to the hypothesis that depression and guilt would be serial mediators of trauma-hypersexual behavior relations. The paths through depression and guilt are the most significant, with moderate and high indirect effects on hypersexuality. Moreover, male gender, as a covariate variable, is a relevant risk factor for hypersexual behavior (Ciocca et al.,2020).

In the research titled "Compulsive Sexual Behavior and Dysregulation of Emotion," the study conducted a literature review to explore the association between compulsive sexual behavior (CSB) and emotion dysregulation (ED). Patterns of DE were evaluated as a common clinical feature, underlying mechanisms, as well as a target for psychological and pharmacological interventions in CSB.

Results came across different conceptualizations of CSB, DE represents the core element of a failure to cope with sexual impulses, thoughts, urges, or resulting in uncontrolled sexual behaviors. DE may contribute to the occurrence of CSB, while for individuals affected by this condition, sexual arousal and release act as an easier/learned (yet uncontrolled and leading to negative consequences) way of coping with negative mood states. CSB may represent a delusive form of self-regulation. Experience of child sexual abuse and insecure attachment patterns are considered risk factors for CSB (likely to be mediated by DE) but require further investigation. DE is also positively associated with CSB symptom severity. Pharmacological treatments affecting mood regulation, anxiety, impulsivity, and regulation within the brain reward system have been reported to help people with CSB achieve better control over their sexual urges and behavior. The study emphasizes the importance of addressing DE in the treatment of CSB (Lew-Starowicz et al., 2020).

A study conducted with the title In the research titled "The Interpersonal Implications of Complex PTSD: The Role of Disturbances in Self-Organization Among War Veterans and Their Spouses" by Lahav, Tuval-Mashiach, and Solomon (2021), the authors examined how complex PTSD (CPTSD) symptoms particularly disturbances in self-organization (DSO), affect not only individuals but also their intimate relationships. Using a dyadic approach, the study involved war veterans diagnosed with CPTSD and their spouses, analyzing the mutual impact of PTSD symptoms on both partners. The research involved a sample of 183 Israeli former prisoners of the 1973 Yom Kippur War (ex-POWs) who participated in a 24-year longitudinal study with three waves of measurements. The researchers employed standardized assessments to measure PTSD symptoms, DSO features, and relational functioning. Results showed that DSO symptoms significantly influenced both the veterans' and their partners' psychological distress and relationship satisfaction, indicating that the interpersonal strain of CPTSD extends beyond the individual (Lahav et al., 2021).

A research titled "Predictors of male sexual dysfunction in Post-Traumatic Stress Disorder", explored how post-traumatic stress disorder (PTSD) affects sexual function in men. Researchers assessed 30 male PTSD patients using clinical interviews and two standardized tools: the PTSD Checklist Scale (PCLS) and the International Index of Erectile Function

(IIEF15). They found that men with PTSD commonly experienced sexual dysfunction, with lower scores in areas like sexual desire, erectile function, orgasm, and satisfaction. Specifically, worse erectile and orgasmic function was linked to more severe PTSD symptoms such as mood and cognitive disturbances, hypervigilance, and reliving traumatic events. The findings highlight the need to consider sexual health when treating men with PTSD, as emotional and cognitive symptoms may strongly influence sexual wellbeing. (Ben Rejeb et al., 2021).

In the research titled "Identifying Relationships Between Difficulties with Emotion Regulation and Compulsive Sexual Behavior," the objective was to examine how facets of emotion dysregulation relate to compulsive sexual behavior (CSB). The study also considered interpersonal emotion regulation via attachment avoidance and attachment anxiety. Hierarchical regression was conducted, first accounting for demographic covariates, then adding attachment styles, and finally all DERS subscales. Results indicated that, among a large, diverse, online U.S. sample (N = 915; Mage = 39.21, SD = 0.81; 54.3% men), difficulty controlling impulses when upset, difficulty with clarity of emotions, and non-acceptance of emotions were significantly positively associated with CSB (small to moderate effects). Attachment anxiety and avoidance were also significantly positively associated with CSB, although their effects were minimal when adding DERS facets. Overall, this study supports the theorized impact of emotion dysregulation on CSB (Grubbs et al., 2023).

In a study titled "Traumatized Sexuality: Understanding and Predicting Profiles of Sexual Behaviors Using Childhood Abuse and Trauma Measures" provides valuable insights into how childhood trauma can shape adult sexual behavior. By analyzing a large, non-clinical sample of 806 individuals through latent profile analysis (LPA), researchers identifies four distinct sexual behavior profiles: hypersexual individuals, hypersexual porn users, general porn users, and individuals within typical sexual behavior ranges (WURs).

The findings highlight that hypersexual porn users tend to report the highest levels of childhood trauma-including emotional, physical, and sexual abuse as well as increased symptoms of PTSD, depression, and anxiety. In contrast, those identified as hyposexual display low sexual interest and motivation, with few signs of emotional distress or trauma.

Furthermore, the study reveals that individuals in the hypersexual and porn-user categories often engage in sexual activities due to coping needs or peer pressure, differing from those in the WUR or hyposexual groups. Gewirtz-Meydan underscores the clinical relevance of these profiles, encouraging therapists who work with trauma survivors to consider how maladaptive sexual behaviors may stem from unresolved trauma and PTSD symptoms (Gewirtz-Meydan et al.,2024).

In the research titled "A Correlational Study of Hypersexuality as a Trauma Response in Indian Young Adults," the study explored the potential correlation between hypersexuality and trauma among Indian young adults. Employing a correlational design, the researchers assessed selfreported traumas and hypersexual behaviors within this demographic. A sample of 100 sexually active participants aged 16-28 was recruited through both online and offline surveys. The final sample included 46 females, 43 males, and 11 non-binary individuals. The selfreported trauma was measured through the Trauma History Questionnaire (THQ), and hypersexual behaviours were measured by the Hypersexual Behavior Inventory (HBI). A statistically significant positive correlation of 0.473 was found between THO and HBI scores.

This indicates that individuals with higher self-reported trauma scores tend to also report higher levels of hypersexual behaviours (Chakravarty and Imran, 2024).

The literature consistently demonstrates a complex interplay between trauma and sexual behavior. Disturbances in self-organization, emotion regulation difficulties, and insecure attachment styles further mediate these relationships. This review established the foundation for investigating the behavioural consequences of trauma, while identifying gaps and inconsistencies that justify the current comparative study.

METHODOLOGY

METHODOLOGY

Methodology refers to the overarching strategy and rationale guiding a research project. It involves the theoretical analysis of the body of methods and principles associated with a field of study. A methodology outlines the approach taken to collect, analyze, and interpret data, ensuring the research is systematic, valid, and reliable. It includes the selection of specific research methods, the justification for their use, and how they align with the research questions or hypotheses (Creswell & Creswell, 2018).

This study aims to examine the severity of trauma symptoms and its effects on sexual behavior through a comparative approach. Specifically, it focuses on understanding how trauma, particularly post-traumatic stress disorder (PTSD) and complex PTSD (C-PTSD), affects sexual desire, hypersexual behavior, and disturbances in self-organization (DSO). The study will compare individuals with trauma histories to those who do not have any history of trauma.

Participants, those who have enddured trauma exhibited patterns of symptoms that aligned with PTSD and Complex PTSD (CPTSD). However, it's important to note that having a formal diagnosis wasn't a requirement for inclusion in the study. To assess these symptoms, researchers utilized the International Trauma Questionnaire (ITQ), a trusted tool designed for both clinical and non-clinical populations. This questionnaire effectively screens for traumarelated symptoms and functional impairments, aligning with the ICD-11 diagnostic criteria (Cloitre et al., 2018).

What's particularly noteworthy is that the severity of symptoms-especially those linked to CPTSD, like disturbances in self-organization and other functional challenges, leads to significant disruption in personal, social, and occupational life. Yet, not having a formal diagnosis doesn't mean someone isn't grappling with serious symptoms. Many individuals endure substantial trauma-related distress without ever receiving a diagnosis, often due to factors like underrecognition, stigma, limited access to services, or personal strategies for coping (Karatzias et al., 2017; Hyland et al., 2020). However, being so deeply accustomed to these impairments, individuals may not even recognize the extent to which their functioning is compromised. They may not consider that living could be less burdensome, that their situation is amenable to improvement, or that their experiences are not universal. This normalization of

suffering can lead to underreporting, lack of help-seeking behavior, and a general absence of formal diagnosis, despite the presence of clinically significant symptoms.

Thus, adopting a symptom-based classification approach with a standardized tool, this study was able to include participants whose trauma responses are not just valid, but also meaningful for research. This perspective aligns with modern trauma research, which emphasizes that understanding the subjective experience of symptoms rather than merely relying on clinical labels-is essential for grasping the genuine impact trauma has on people's lives.

The study employs a quantitative, between-groups design to investigate the associations mentioned above. It compares the psychological profiles of three participant groups: individuals with PTSD, individuals with C-PTSD symptoms, and individuals without trauma histories. This design enables an examination of the differences between the groups on several key variables, including Hypersexual behavior, Sexual desire, PTSD symptoms, PTSD, DSO, and DSO impairment.

Standardized instruments have been used to measure trauma-related symptoms, sexual desire, hypersexual behavior, and functional impairment. Data collection was conducted through validated self-report measures, ensuring psychometric reliability and enabling the assessment of psychological constructs relevant to trauma and sexuality. Given the expected variation in symptom severity and behavioral expression across the three groups, rigorous statistical analyses were used. These included descriptive statistics, normality testing via Shapiro-Wilk, Kruskal–Wallis's test to account for unequal variances.

This study utilized three validated self-report instruments to assess trauma-related symptoms, hypersexual behavior, and sexual desire. The International Trauma Questionnaire (ITQ) was used to evaluate symptoms of PTSD and Complex PTSD (C-PTSD) based on ICD-11 criteria (Cloitre et al., 2018). The Hypersexual Behavior Inventory (HBI-19) measured the frequency and psychological impact of hypersexual behavior, focusing on dimensions such as control, coping, and consequences (Reid et al., 2011). The Sexual Desire Inventory–2 (SDI-2) assessed both shared (dyadic) and individual (solitary) sexual desire to gauge variations in sexual interest (Spector et al., 1996).

OBJECTIVES:

The present study was aimed -

- To find out if there is any significant difference between people with C-PTSD, PTSD. and individuals with no trauma history with respect to hypersexuality.

- To find out if there is any significant difference between people with C-PTSD, PTSD. and individuals with no trauma history with respect to sexual desire.

- To find out if there is any significant difference between people with respect to PTSD symptoms among the CPTSD, PTSD, and individuals with no trauma history.

- To find out if there is any significant difference between people with C-PTSD, PTSD. and individuals with no trauma history with respect to PTSD impairment.

- To find out if there is any significant difference between people with C-PTSD, PTSD. and individuals with no trauma history with respect to disturbances in selforganization..

- To find out if there is any significant difference between people with C-PTSD, PTSD. and individuals with no trauma history with respect to disturbances in self-organization impairment..

HYPOTHESIS:

On the basis of previous studies following hypotheses were formulated-

H1: There is a significant difference in hypersexual behavior among the CPTSD, PTSD, and Control groups.

H2: There is a significant difference in sexual desire among the CPTSD, PTSD, and Control groups.

H3: There is a significant difference in PTSD symptoms among the CPTSD, PTSD, and individuals with no trauma history.

H4: There is a significant difference in PTSD related functional impairment among the CPTSD, PTSD, and individuals with no trauma history.

H5: There is a significant difference in disturbances in self-organization among the CPTSD, PTSD, and individuals with no trauma history.

H6: There is a significant difference in disturbances in self-organization impairment among the CPTSD, PTSD, and individuals with no trauma history.

For the present study, these dimensions have been defined operationally

OPERATIONAL DEFINITIONS:

Trauma: Trauma is a psychological and emotional response to distressing or life-threatening events, which can overwhelm an individual's ability to cope. It can stem from experiences such as abuse, violence, disasters, or serious accidents, and often leads to lasting psychological challenges (Oxford Dictionary of Psychology, Colman, 2015).

Post-traumatic stress disorder: PTSD, or post-traumatic stress disorder, is a psychiatric condition that can develop after someone experiences a traumatic event. It is characterized by ongoing symptoms, which include re-experiencing the trauma (such as through flashbacks or nightmares), avoidance of reminders of the event, negative changes in thoughts and mood, and increased alertness or arousal. This disorder can significantly disrupt a person's daily functioning and sense of safety, often leading to intrusive memories and emotional numbness (American Psychiatric Association, 2013).

Complex PTSD (C-PTSD): C-PTSD, or Complex Post-Traumatic Stress Disorder, is a condition that develops after experiencing prolonged or repeated interpersonal trauma, such as childhood abuse or captivity. It includes the main symptoms of PTSD, but also features disturbances in self-organization. These disturbances may involve emotional dysregulation, a persistent negative self-concept, and challenges in interpersonal relationships (World Health Organization, 2018; Herman, 1992).

PTSD symptoms: PTSD symptoms include psychological effects following trauma, such as flashbacks, intrusive thoughts, hypervigilance, avoidance of trauma-related stimuli, sleep disturbances, and emotional detachment. These symptoms are involuntary and consistently disrupt daily life (APA Dictionary of Psychology, 2022).

PTSD impairment: PTSD-related impairment refers to the significant disruption of personal, social, occupational, or academic functioning due to post-traumatic symptoms. This impairment impacts an individual’s ability to maintain relationships, perform tasks, and engage meaningfully in everyday life (APA, 2013).

Hypersexual behavior: Hypersexual behavior refers to an intense and often compulsive preoccupation with sexual activities or fantasies. This heightened engagement can manifest as a persistent urge to seek out sexual experiences, frequently leading individuals to feel a significant loss of control over their impulses. Such behavior is often rooted in a maladaptive coping mechanism, where sex is used as an escape from underlying emotional distress or psychological issues. As a result, hypersexuality can create considerable turmoil in a person's life, triggering distress, strained interpersonal relationships, and dysfunction across various aspects of daily living (Kafka, 2010; Oxford Dictionary of Psychology, Colman, 2015).

Sexual desire: Sexual desire is a complex motivational state characterized by an interest in engaging in sexual activities. This desire can be directed towards others, known as dyadic desire, or toward oneself, termed solitary desire. It encompasses not only the biological impulses that drive individuals toward sexual contact but also the intricate cognitive and emotional experiences associated with yearning for intimacy. This multifaceted experience is shaped by a blend of physiological arousal and the nuanced feelings and thoughts about sexual connections (Regan and Berscheid in 1995.

DSO or Disturbances in self-organization: Disturbances in self-organization refer to chronic disruptions in affect regulation, self-concept, and interpersonal relationships that result from

repeated or prolonged trauma. DSO reflects impairments in emotional balance, identity coherence, and social connectedness (Cloitre et al., 2020; WHO, 2018).

METHODS:

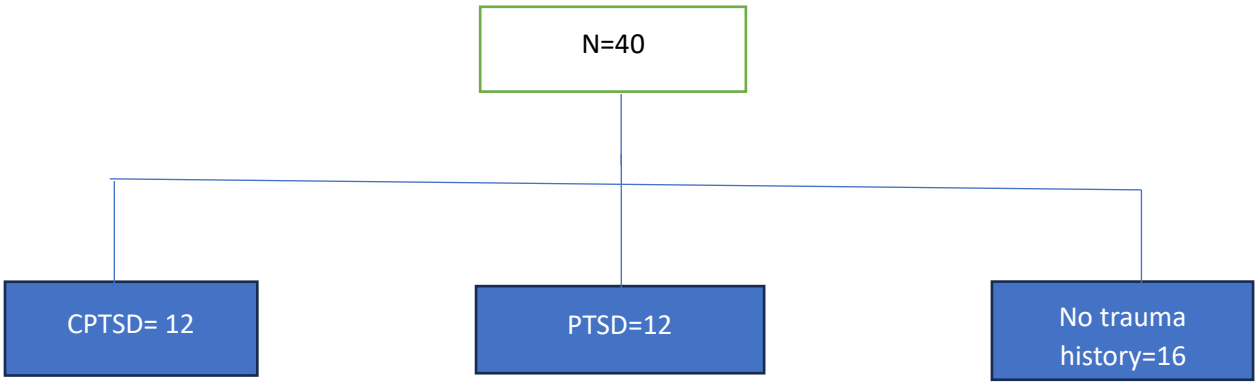
Sample:

The study employed a purposive sampling technique to select participants from three distinct groups: those meeting the criteria of Post-Traumatic Stress Disorder (PTSD), those meeting the criteria for Complex PTSD (C-PTSD), and a control group consisting of individuals without any self-reported history of trauma exposure. This non-probability sampling method was chosen to ensure that participants were relevant to the study's specific objectives. To be included, participants had to be adults aged 18 or older, capable of understanding the study's requirements, and willing to provide informed consent. Participants were assigned based on their self-reported symptomatology, while the control group was carefully screened to ensure no history of trauma.

The study initially recruited 63 individuals. Among these, 37 participants were selected based on their self-reported trauma exposure and categorized into PTSD or C-PTSD groups based on their scores from the International Trauma Questionnaire. However, 13 of these individuals did not meet the eligibility criteria for grouping participants, as it was required for the study (as it allows for the investigation of trauma-related outcomes in a way that is valid and clinically applicable, especially within community, non-clinical samples). So the study consisted of a 24trauma population.

Furthermore, 26 individuals without a history of trauma were recruited, and from this group, 21 successfully signed the informed consent and submitted the questionnaire booklet.

After thorough data screening and verification, 16 of them were considered, and a total of 40 participants were included in the final sample for analysis.



Inclusive Criteria:

- Adults aged 18 to 50 years of age.
- Self-reported history of trauma exposure, at least one event personally perceived as traumatic.
- Indicated symptoms consistent with PTSD or C-PTSD or obtained the score that places them in either of the groups as measured by the International Trauma Questionnaire (ITQ).
- Language proficiency: must be able to read and comprehend the language.
- Willingness to respond to sensitive questions related to trauma and sexual behavior without coercion.

For the individuals with no trauma history:

- No self-reported history of trauma exposure or psychological distress related to trauma and did not meet the diagnostic criteria for PTSD, C-PTSD.

Exclusion criteria:

- Individuals under 18 and above 50 years of age.
- Participants with unclear trauma histories not meeting PTSD or C-PTSD symptoms thresholds.
- History of neurological disorders or known diagnosis of any psychiatric condition.
- Participants reporting trauma but not meeting criteria for functional or core symptoms.
- Those who have no understanding of the English language. ● Participants from a psychology background.

Description of the tools:

1. Demographic details

An information schedule was used to gather demographic details - name, age, gender, sexual orientation, education level, employment status, relationship status, socioeconomic status, geographic location, and family mental health history.

11. International Trauma Questionnaire (ITQ)

The International Trauma Questionnaire (Cloitre et al., 2018) is a self-report instrument designed to assess the core symptoms of Post-Traumatic Stress Disorder (PTSD) and Complex PTSD (C-PTSD) based on the ICD-11 criteria.

PTSD subscale Cronbach's alpha = .87–.90. DSO subscale α = .88–.91. Full scale α = .91–.94

Test-Retest Reliability: Studies show high stability over 2–4 weeks, with intraclass correlation coefficients (ICCs) around .75–.89

It comprises 12 symptom items and 6 functional impairment items, divided into two subscales:

- PTSD symptoms: re-experiencing, avoidance, and a sense of threat.
- Disturbances in Self-Organization (DSO): affective dysregulation, negative selfconcept, and disturbances in relationships.

Administrative:

All questionnaires were administered in a paper-and-pencil format. Participants rate the severity of each symptom on a 5-point Likert scale ranging from 0 (Not at all) to 4 (Extremely) over the past month. Functional impairments associated with both PTSD and DSO are rated using a similar scale, indicating how much these symptoms affect their personal, social, and occupational functioning.

Scoring:

A clinical threshold is met when a participant reports at least one symptom in each cluster, scoring ≥2, along with corresponding functional impairment.

III. Hypersexual Behavior Inventory (HBI)

All questionnaires were administered in a paper-and-pencil format. The Hypersexual Behavior Inventory (Reid et al., 2011) is a 19-item self-report measure used to assess hypersexuality as a clinical construct. Reliability analysis found high internal reliability for the overall scale (alpha = .96) and subscales (Control, alpha = .95, Coping, alpha = .91, and Consequences, alpha = .89).

The instrument captures three domains:

Control: difficulty managing sexual thoughts, urges, and behavior.

Consequences: experiencing negative outcomes as a result of sexual activity.

Coping: using sex as a coping mechanism for emotional stress.

Administrative:

This is a self-administered test. Participants were asked to rate each item on a 5-point Likert scale from 1 (Never) to 5 (Very often), with higher scores indicating greater hypersexual tendencies. A total score of 53 or above suggests clinically significant hypersexual behavior. The HBI has demonstrated high internal consistency ($\alpha > .90$) and has been widely used in both clinical and non-clinical samples.

Scoring: Sum scores are computed by adding the scores on the items per subtest.

IV: The Sexual Desire Inventory:

The Sexual Desire Inventory (Spector et al., 1996) assesses levels of sexual desire in both solitary and dyadic contexts.

Cronbach's alpha coefficients for the overall scale are typically reported between .86 to .95. Subscales (Dyadic Sexual Desire and Solitary Sexual Desire) also show strong internal consistency (e.g., $\alpha = .86$ to .89 for Dyadic Desire; $\alpha = .83$ to .88 for Solitary Desire). Testretest reliability over a few weeks has been reported as good, with correlations around $r = .81$ over a 2–4 week period (Spector et al., 1996).

The 14-item scale includes subscales such as:

Dyadic sexual desire: interest in sexual activity with a partner.

Solitary sexual desire: interest in engaging in sexual activity alone.

Administration:

All questionnaires were administered in a paper-and-pencil format. Participants respond on a Likert-type scale, where frequency-based items range from 0 (Not at all) to 8 (More than once a day), and intensity-based items range from 1 (No desire) to 9 (Strong desire). Higher scores reflect greater levels of sexual desire.

Scoring: Sum scores are computed by adding the scores on the items per subtest.

Procedure for data collection:

All participants were contacted personally, and rapport was established before they signed a consent form. They received a brief overview of the study's aims, along with instructions related to the questionnaire. Participants were assured that their information would be kept confidential and used solely for research purposes, encouraging them to be open and honest in their responses. Following this, the scales were administered, and data were collected.

Statistical analysis:

All statistical analyses were conducted using Jamovi software, version 2.3.28 was used. Descriptive statistics, including means, medians, standard deviations, skewness, and kurtosis, were calculated to summarize the data and examine the distributional characteristics of each variable within the groups. Shapiro-Wilk tests of normality were performed to determine whether the variables were normally distributed within each group. As normality was deviated, suitable non-parametric or robust statistical methods were applied. In the last phase, to test for between-group differences, **the Kruskal–Wallis test** was performed for each dependent variable.

RESULTS AND INTERPRETATION

RESULTS AND INTERPRETATION

TABLE 1: RESULTS ON THE DISTRIBUTION OF NORMALITY

	Participant groups	HYPERSEXUAL BEHAVIOR	SEXUAL DESIRE	PTSD symptoms	PTSD IMPAIRMENT	DISTURBANCES IN SELFORGANIZATION	DISTURBANCES IN SELF-ORGANIZATION IMPAIRMENT
N	CPTSD	12	12	12	12	12	12
	Control	16	16	16	16	16	16
	PTSD	12	12	12	12	12	12
Mean	CPTSD	49.8	68.6	16.0	8.42	17.4	8.08
	Control	27.9	40.3	4.38	2.38	6.63	1.63
	PTSD	30.7	39.2	11.8	4.75	8.25	3.17
Skewness	CPTSD	-0.462	-1.15	-0.389	0.100	-0.745	-0.133

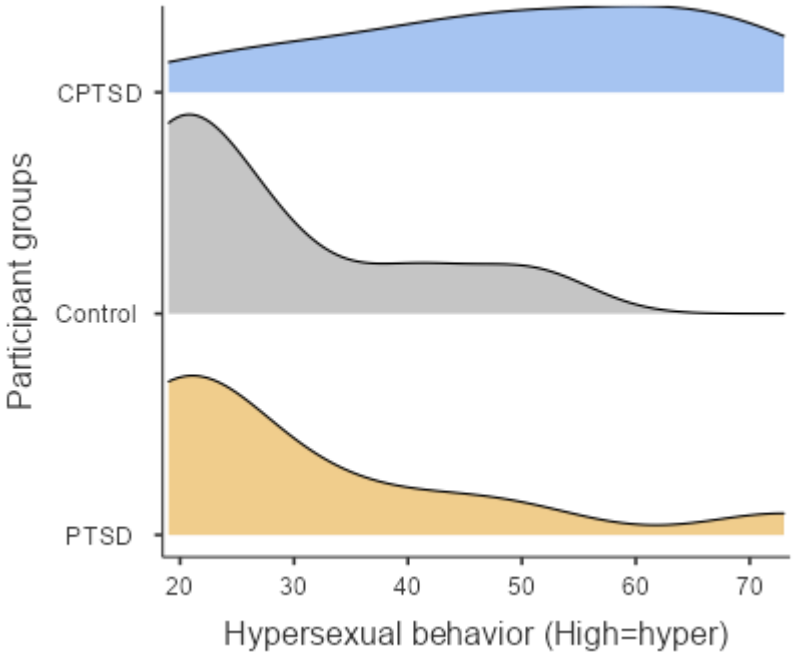
	Control	**1.18**	**0.108**	**0.510**	**1.20**	**0.575**	**2.22**
	PTSD	**1.75**	**0.547**	**0.0630**	**0.885**	**0.333**	**0.193**
Std. error skewness	**CPTSD**	**0.637**	**0.637**	**0.637**	**0.637**	**0.637**	**0.637**
	Control	**0.564**	**0.564**	**0.564**	**0.564**	**0.564**	**0.564**
	PTSD	**0.637**	**0.637**	**0.637**	**0.637**	**0.637**	**0.637**
Kurtosis	**CPTSD**	**-0.875**	**-0.00866**	**-1.13**	**-1.55**	**0.0293**	**-0.910**
	Control	**0.0587**	**-1.14**	**-0.258**	**0.121**	**-1.18**	**4.54**
	PTSD	**2.85**	**-0.709**	**2.07**	**-0.345**	**-0.618**	**0.490**
Std. error kurtosis	**CPTSD**	**1.23**	**1.23**	**1.23**	**1.23**	**1.23**	**1.23**
	Control	**1.09**	**1.09**	**1.09**	**1.09**	**1.09**	**1.09**
	PTSD	**1.23**	**1.23**	**1.23**	**1.23**	**1.23**	**1.23**
ShapiroWilk W	**CPTSD**	**0.931**	**0.825**	**0.885**	**0.919**	**0.931**	**0.936**
	Control	**0.771**	**0.908**	**0.944**	**0.774**	**0.875**	**0.638**
	PTSD	**0.756**	**0.929**	**0.911**	**0.853**	**0.946**	**0.943**
ShapiroWilk p	**CPTSD**	**0.393**	**0.018**	**0.100**	**0.278**	**0.393**	**0.454**
	Control	**0.001**	**0.107**	**0.395**	**0.001**	**0.032**	**<.001**
	PTSD	**0.003**	**0.369**	**0.217**	**0.040**	**0.574**	**0.543**

Table 1: From the Shapiro-Wilk p-values, the analysis indicates that certain variables demonstrated statistically significant deviations from normality.

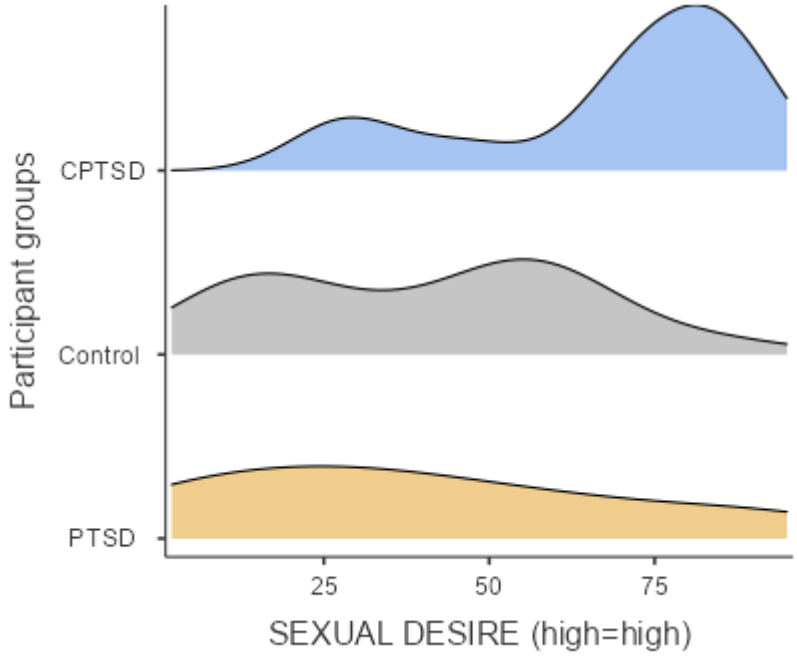
Therefore, non-parametric statistics have been used.

GRAPHICAL REPRESENTATION:

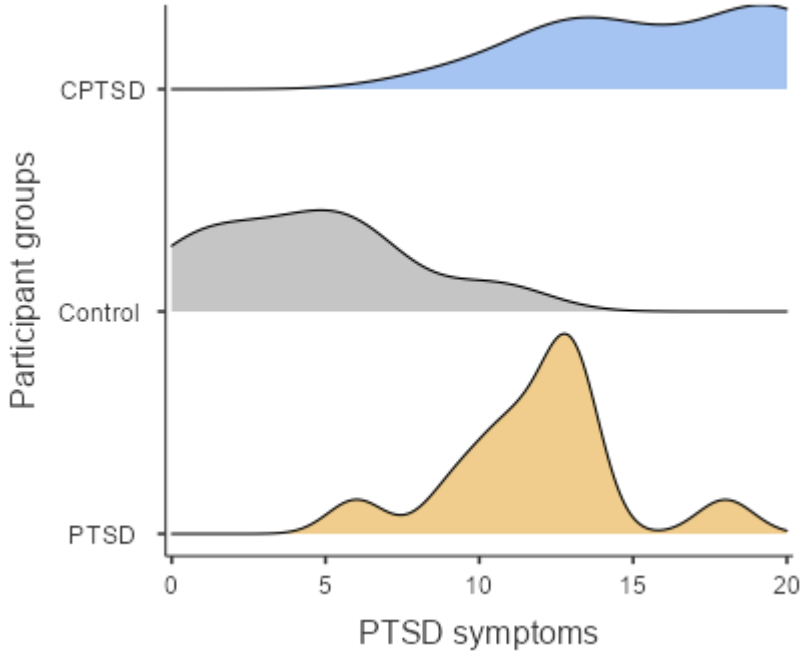
HYPERSEXUAL BEHAVIOR



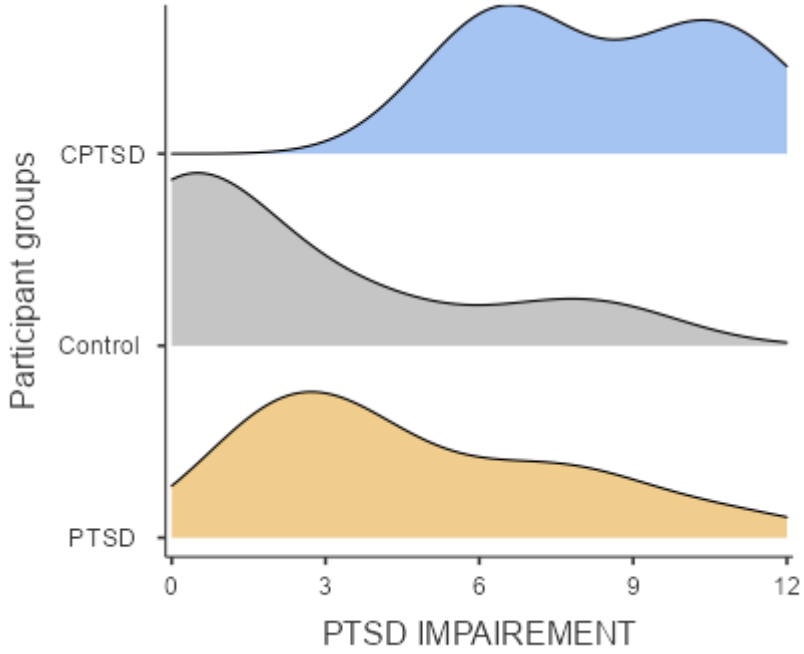
SEXUAL DESIRE (high=high)



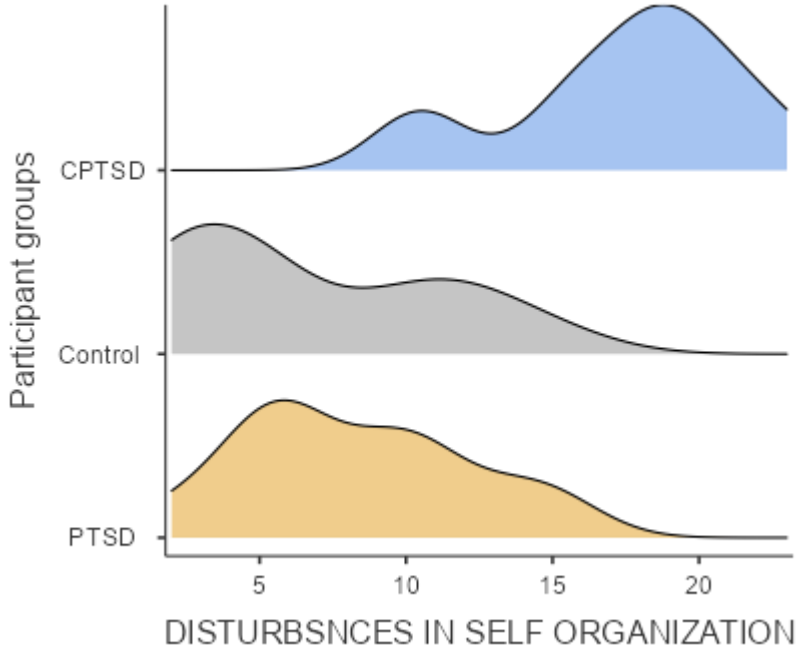
PTSD symptoms



PTSD IMPAIRMENT



DISTURBANCES IN SELF-ORGANIZATION



DISTURBANCES IN SELF-ORGANIZATION IMPAIRMENT

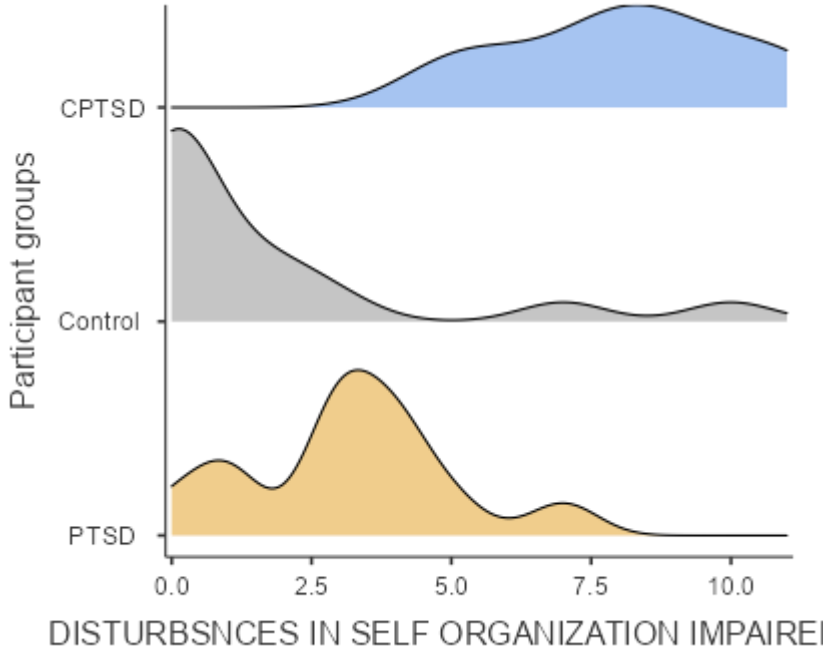


TABLE 2: RESULTS ON DESCRIPTIVE STATISTICS

	Participant groups	HYPERSEXUAL BEHAVIOR	SEXUAL DESIRE	PTSD symptoms	PTSD IMPAIRMENT	DISTURBANCES IN SELF-ORGANIZATION	DISTURBANCES IN SELF-ORGANIZATION IMPAIRMENT
N	**CPTSD**	12	12	12	12	12	12
	Control	16	16	16	16	16	16
	PTSD	12	12	12	12	12	12
Mean	**CPTSD**	49.8	68.6	16.0	8.42	17.4	8.08
	Control	27.9	40.3	4.38	2.38	6.63	1.63
	PTSD	30.7	39.2	11.8	4.75	8.25	3.17
Median	**CPTSD**	51.0	75.5	16.5	8.00	18.5	8.00

	Control	23.0	46.0	4.50	1.00	5.00	0.00
	PTSD	22.5	32.0	12.5	3.50	7.50	3.00
Mode	**CPTSD**	20.0[a]	27.0[a]	20.0	7.00	19.0	8.00
	Control	19.0	59.0	6.00	0.00	2.00	0.00
	PTSD	19.0	2.00[a]	13.0	2.00	6.00	3.00
Standard deviation	**CPTSD**	16.4	22.0	3.81	2.35	3.92	2.07
	Control	11.5	23.4	3.28	3.12	4.47	2.90
	PTSD	16.8	31.2	2.89	3.05	3.91	1.90

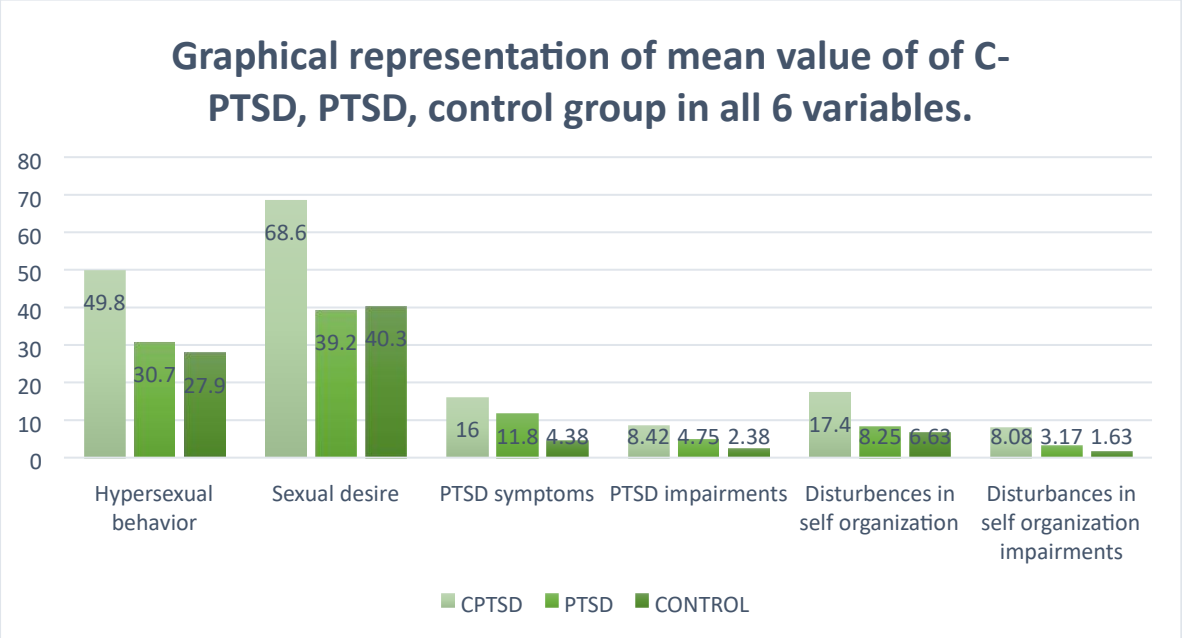


Table No. 2 indicates the mean of CPTSD, PTSD, and the Control group.

TABLE 3: INFERENTIAL STATISTICS:

Kruskal Wallis Test	F	df	df2	P
Hypersexual behavior	7.68**	2	21.3	0.003
SEXUAL DESIRE	6.19**	2	22.8	0.007
PTSD symptoms	39.54***	2	23.4	<.001
PTSD IMPAIRMENT	17.14***	2	23.9	<.001
DISTURBANCES IN	25.91***	2	24.1	<.001
DISTURBANCES IN ORGANIZATION IM	28.14***	2	24.6	<.001

DISCUSSION

DISCUSSION

Discussion on the normality of the distribution:

Table No. 1 indicates normality test results (using the Shapiro-Wilk test) for six psychological variables: hypersexual behavior, sexual desire, PTSD symptoms, PTSD-related impairment, disturbances in self-organization (DSO), and DSO-related impairment. Data are compared across three participant groups: individuals with Complex PTSD (CPTSD), PTSD, and a control group with no trauma-related diagnosis.

From the Shapiro-Wilk p-values, the analysis indicates that certain variables demonstrated statistically significant deviations from normality. Therefore, non-parametric statistics have been used.

Ghasemi and Zahediasl (2012) discussed how small sample sizes frequently fail normality tests, emphasizing the need for appropriate statistical adjustments.

Discussion on descriptive statistics:

In table No. 2, the CPTSD group exhibited the highest mean scores across all variables. This indicates a significant dysregulation in both sexual behavior and arousal, which aligns with the severity of symptoms and emotional dysregulation often seen in individuals with CPTSD (Cloitre et al., 2013).

Hypersexual Behavior - CPTSD group shows the highest mean (49.8) compared to PTSD (30.7) and Control (27.9). This suggests individuals with CPTSD display elevated levels of hypersexual behavior.

Sexual Desire - CPTSD group again shows the highest mean sexual desire (68.6), compared to PTSD (39.2) and Control (40.3). although high sexual desire is not always indicative of hypersexuality, however may reflect emotional dysregulation or trauma-driven sexual reactivity (Bancroft & Vukadinovic, 2004).

PTSD Symptoms – Mean of CPTSD (16.0) and PTSD (11.8) report higher PTSD symptom levels than the control group (4.38).

PTSD-Related Impairment – Impairment mean scores are highest for CPTSD (8.42), followed by PTSD (4.75), and lowest in control (2.38).

Disturbances in Self-Organization (DSO) - DSO symptoms are most elevated in CPTSD (mean = 17.4), followed by PTSD (8.25) and control (6.63).

DSO Impairment is also highest in CPTSD (8.08), reinforcing that identity, emotion regulation, and relational difficulties are core features of CPTSD (Cloitre et al., 2013).

The control group shows high positive skewness and kurtosis, especially in DSO impairment (skewness = 2.22, kurtosis = 4.54), indicating that most participants scored low, with a few scoring unusually high.

The CPTSD group's values are mostly near zero or mildly negative.

The PTSD group displays moderate skewness and kurtosis.

The Trauma Heterogeneity Theory, introduced by Cloitre and colleagues in 2009, clearly demonstrates that individuals exposed to trauma exhibit significant variability in symptom expression, psychological functioning, and coping mechanisms. It is essential to understand that not all trauma survivors develop PTSD or Complex PTSD (C-PTSD); the outcomes are influenced by critical factors such as the type, severity, and duration of the trauma, as well as individual vulnerabilities and the availability of support systems.

This inherent variability results in clinical and research samples of trauma survivors being highly heterogeneous. Consequently, we observe non-normal statistical distributions, diverse levels of symptom severity, and complex behavioral manifestations, including hypersexuality and sexual withdrawal.

The presence of skewed or non-normal data in trauma research, as reflected in your descriptive statistics, is a predictable outcome of the underlying trauma heterogeneity. This validates the

complexity seen in symptom patterns and sexual behaviors, reinforcing the necessity of recognizing and addressing this diversity in trauma research.

CPTSD is associated with greater emotional dysregulation, interpersonal difficulties, and dissociation (Herman, 1992; Cloitre et al., 2013), which can result in wider variability and higher mean scores, particularly for sexual behavior and DSO-related measures. van der Kolk (2014) emphasized how trauma alters the brain's regulation of emotional and sexual functioning, potentially contributing to the unpredictable and skewed patterns in traumaaffected individuals.

Median-mode: Median and mode values CPTSD group show consistently higher central tendency values across all variables.

Research shows hypersexual behavior is commonly observed in individuals with complex trauma, especially those with histories of childhood sexual abuse (Kafka, 2010; Briere & Elliott, 1994).

Cloitre et al. (2014) noted that CPTSD symptoms, especially affective dysregulation and negative self-concept, are linked with "interpersonal and sexual dysfunctions". High sexual desire perhaps represents either dysregulated attachment needs or compulsive sexual activity.

Karatzias et al. (2019) found that DSO symptoms are predictive of functional impairments, especially in emotional regulation and intimacy, often translating into hypersexual or hyposexual behavior as manifestations of trauma.

Discussion on the comparison among groups

1. **Hypersexual behavior :** $F = 7.68$, $p = 0.003$

   So, there is a significant difference in scores across the three groups (CPTSD, PTSD, Control). **Thus, the alternative hypothesis H1 is accepted.**

   CPTSD's higher score suggests that sexual behavior may be used both as a coping mechanism and a dysregulated expression of unresolved trauma.

   This aligns with clinical literature showing that survivors of prolonged abuse or neglect may develop maladaptive patterns of intimacy-seeking or emotional numbing through sex (Briere & Scott, 2014; Meston et al., 2006).

And previous research also supported, hypersexual behavior has been empirically linked to early trauma and CPTSD symptoms such as affective dysregulation and dissociation (Briere & Elliott, 1994; Carnes, 2001).

Affective dysregulation theory suggests that individuals with Complex PTSD (CPTSD) experience significant challenges in regulating their emotions due to their traumatic experiences. This often leads to maladaptive coping mechanisms, such as hypersexuality, which helps these individuals manage distressing feelings (Van der Kolk, 2005). Survivors of complex trauma often experience intensive affective states, which they try to manage through these strategies. This theory explains why participants with CPTSD scored substantially higher in hypersexual behaviors compared to those with PTSD and control groups. Hypersexuality in this context may be interpreted as an effort to regulate overwhelming internal states or reestablish a sense of control/agency over body and interpersonal boundaries.

2. **Sexual desire:** F =6.19, p 0.007

   Indicative of a significant difference exists in sexual desire level. **Thus, the alternative hypothesis H2 is accepted.**

   Increased sexual desire may co-occur with complex trauma as a dysregulated desire possibly linked to hypersexuality.

   Bancroft et al. (2003) demonstrated how emotional instability and trauma history modulate sexual desire patterns, making it either suppressed or heightened depending on context.

The **Dual control model of sexual response** illustrates how trauma can affect the balance between excitatory and inhibitory sexual processes. For example, individuals with CPTSD may experience heightened sexual excitement, while those with PTSD may show lower sexual desire. This framework underscores the statistically significant differences in sexual drive observed among the groups.

3. **PTSD symptoms:** F =39.54, p < .001

   This is a highly significant result, suggesting very strong differences in PTSD symptom severity between groups. **Thus, the alternative hypothesis H3 is accepted.** High PTSD symptoms in the CPTSD group may be indicative of traumatic memories insufficiently processed, resulting in fear structure that persists and causes distress.

Cloitre et al. (2014) and Hyland et al. (2017) consistently found significantly higher PTSD scores in clinical groups, especially those with CPTSD.

The Emotional Processing Theory, proposed by Foa and Kozak (1986), explains that trauma memories are stored in a "fear structure" within memory networks. This structure contains information about the feared stimulus, the fearful responses, and their meaning. In PTSD, these fear structures are maladaptive and overly rigid, preventing normal emotional resolution. Traumatic memories are thus re-experienced through flashbacks, nightmares, and intrusive thoughts because they have not been sufficiently processed or integrated into autobiographical memory.

4. **PTSD Impairment:** $F = 17.14$, $p = .001$

   Indicates statistically significant difference in PTSD – related functional impairment across groups. **Thus, the alternative hypothesis H4 is accepted.**

   High impairment associated with PTSD, which is social, occupational dysregulation, results from maladaptive appraisals, and its consequences.

   CPTSD typically results in greater social, occupational, and emotional impairment than PTSD alone (Karatzias et al., 2019).

5. **Disturbances in self-organization:** $F = 25.91$, $p < .001$

   Significant difference in DSO symptoms between the CPTSD, PTSD, and Control groups. **Thus, the alternative hypothesis H5 is accepted.**

   High DSO in CPTSD may stem from a disrupted attachment system due to early trauma or relational disruptions, or distrust.

Polyvagal theory (Porges, 2011) adds another layer of understanding by explaining how trauma disrupts the autonomic nervous system, causing individuals to oscillate between states of hyperarousal and shutdown as a defensive response, like an example, some individuals may seek compulsive sexual encounters as a form of hyperarousal-driven coping, while others may exhibit hyposexuality due to parasympathetic shutdown and disconnection. These shifts can influence sexual behavior, resulting in either increased sexual desire or compulsive behaviors, depending on the individual's state of emotional regulation. The variations in sexual desire across the trauma groups, especially the heightened desires in the CPTSD group, support this neurophysiological perspective.

6. **Disturbances in self-organization impairment:** $F = 28.14$, $p < .001$

   This shows a highly statistically significant difference between the CPTSD, PTSD, and Control groups. **Thus, the alternative hypothesis H6 is accepted.**

   This implies how strongly these disturbances affect real-life functioning (like relationships, work, etc.), which is persistent and pervasive. Hyland et al., (2017), Cloitre et al., (2019) pointed out DSO DSO-related impairments can severely affect quality of life and treatment outcomes.

The elevated hypersexual behavior among CPTSD participants and profound DSO impairment can be understood through the **Compensatory model of hypersexuality** (Raid et al., 2010). This model posits that compulsive sexual behaviors may serve as coping strategies for dealing with negative emotions, emotional pain, shame, and traumatic memories etc, particularly for those who have experienced emotional neglect or abuse.

These interrelated theoretical frameworks provide a comprehensive understanding of how trauma influences sexual behavior, emotional regulation, and identity formation. The study's findings underscore the complex psychological and behavioral consequences of trauma, which may emerge as a behavioral manifestation of unprocessed trauma, especially in those with complex symptomatology.

CONCLUDING REMARKS

Concluding Remarks

This study decisively investigates the complex relationship between trauma and sexual behavior, focusing on how hypersexuality and hyposexuality manifest in individuals with posttraumatic stress disorder (PTSD) and Complex PTSD (CPTSD). Through rigorous quantitative comparisons between those with PTSD and CPTSD and control groups comprising individuals without trauma histories, the findings clearly demonstrate that varying trauma-related symptom profiles significantly impact patterns of sexual desire and regulation.

Aligned with established theoretical frameworks such as Affective dysregulation theory, which suggests that emotional regulation challenges can lead to inappropriate sexual behaviors; Polyvagal theory, which emphasizes the role of the autonomic nervous system in regulating emotional states; and the Compensatory model of hypersexuality, which posits that hypersexual behavior may serve as a coping mechanism for unresolved trauma, the study compellingly demonstrates that individuals with CPTSD exhibit markedly higher levels of hypersexual behavior and greater disturbances in self-organization compared to those with PTSD or no history of trauma. These findings illuminate the psychological complexities involved in trauma's impact on sexual functioning and personal identity, highlighting the dual role of sexuality as both a symptom of trauma and a maladaptive coping strategy in the aftermath of traumatic experiences.

This research constitutes a significant contribution to the field of trauma psychology by providing empirical evidence that distinguishes the nuanced behavioral consequences of PTSD versus CPTSD, particularly within the often-stigmatized domain of sexuality, a subject frequently neglected or pathologized in clinical discussions. It emphasizes the necessity of conceptualizing trauma-related sexual behaviors not merely as dysfunctions or symptoms, but as adaptive responses that can be deeply rooted in the need for survival, affect regulation, and the fragmentation of one's identity following trauma. By expanding our understanding of these

behaviors, the study strengthens the call for the implementation of trauma-informed frameworks that respect and integrate the complex interplay of relational, emotional, and somatic experiences in clinical assessment and intervention efforts.

The following conclusion has been drawn,

1. There is a significant difference in hypersexual behavior among the CPTSD, PTSD, and Control groups.

2. There is a significant difference in sexual desire among the CPTSD, PTSD, and Control groups.

3. There is a significant difference in PTSD symptoms among the CPTSD, PTSD, and Control groups.
4. There is a significant difference in PTSD related functional impairment among the CPTSD, PTSD, and Control groups.

5. There is a significant difference in disturbances in self-organization among the CPTSD, PTSD, and Control groups.

6. There is a significant difference in disturbances in self-organization impairment among the CPTSD, PTSD, and Control groups.

Limitations of the present study:

Despite its contributions, the present study is not without limitations, and the following aspects may be regarded as limitations of this study

1. Due to time constraints compromise had to be made concerning sample size. The limited number of participants, especially in the PTSD and CPTSD groups, may reduce statistical power and limit the generalizability of the findings.
2. The study's design restricts the ability to draw causal inferences about the directionality between trauma and sexual behavior.
3. Data collection relied solely on self-report instruments, which are susceptible to social desirability bias, memory distortion, and personal discomfort in disclosing sensitive information.
4. PTSD and CPTSD diagnoses were not confirmed through structured clinical interviews.

5. The study did not account for cultural or gender-based differences that may influence how trauma impacts sexual behavior.
6. The exclusive use of quantitative measures limited the depth of understanding regarding participants' subjective experiences and personal narratives.

Implications of the present study:

The findings of this research offer valuable insights for enhancing clinical practice, informing theoretical frameworks, and guiding policy development in the realms of trauma and sexual health.

Clinically, these results encourage a more compassionate and nuanced approach to assessing and treating sexual behaviors among individuals who have experienced trauma. Rather than viewing hypersexuality or sexual avoidance as strictly pathological, therapists and clinicians are urged to understand these behaviors as potentially adaptive responses to emotional dysregulation, relational trauma, and disrupted self-organization often seen in the wake of traumatic experiences.

By embracing this perspective, professionals are better positioned to design interventions that target underlying issues, rather than simply addressing surface-level symptoms. Integrating trauma-informed care principles into sexual health and psychotherapy services, such as fostering a sense of safety and empowering clients, can lead to meaningful improvements in therapeutic outcomes and encourage deeper engagement from clients.

Theoretically, this study contributes to the expanding body of literature that emphasizes the importance of distinguishing between Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (CPTSD), particularly in the context of the International Classification of Diseases (ICD-11) framework. The research highlights variations in sexual behavior and disturbances in self-organization between individuals diagnosed with PTSD and those with CPTSD, thereby affirming the clinical relevance of this distinction. These findings encourage further refinement of diagnostic criteria to incorporate sexuality as a critical dimension in understanding trauma responses, ultimately leading to more effective assessments and interventions.

On a broader level, the research carries valuable sociocultural and public health implications. By elucidating the sexual consequences of unresolved trauma, it calls on mental health professionals, educators, and policymakers to acknowledge the integral role that sexuality plays in post-trauma recovery, identity development, and social reintegration. Destigmatizing trauma-related sexual behaviors is essential for creating environments where these individuals feel safe and understood. Furthermore, establishing supportive and inclusive spaces for open discussions about these issues can empower individuals in their healing journeys, contributing to a holistic approach to recovery that addresses both mental and sexual health.

Suggestions for further research:

Due to time constraints and other difficulties, the study area could not be extended. But this topic has huge potential to make an impact in trauma research, so inevitable that there are enough opportunities for further research. Further research may be taken up in the following area.

1. Expanding the sample size and including participants from varied cultural, ethnic, and gender backgrounds will enhance generalizability and representation.
2. Future research should track individuals over time to understand how trauma-related sexual behaviors change across recovery phases.
3. Combining quantitative data with qualitative interviews or narrative methods can capture the complexity of the topic.
4. Future studies should use structured clinical interviews to ensure accurate classification of PTSD and CPTSD.
5. Future work should focus on creating and validating therapeutic models specifically targeting trauma-related hypersexuality and hyposexuality.
6. Future research could investigate how trauma-related changes in sexual behavior impact intimacy, attachment, and relationship satisfaction.
7. Investigate how trauma impacts sexual behavior differently in men, women, and nonbinary individuals, especially in terms of sexual identity, emotional regulation, and behavior patterns.
8. Studies should explore how masculinity, social expectations, and stigma shape their experiences of hypersexuality and hyposexuality.

9. Studies can explore how early attachment disruptions contribute to trauma-related sexual dysregulation in adulthood, particularly through anxious, avoidant, and disorganized attachment style.

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APPENDICES

APPENDIX A

(Consent Form)

Informed Consent Form for Participation in Research

Research Title: *Hypersexual Behavior, Sexual Desire, and Disturbances in SelfOrganization Among Individuals With PTSD, C-PTSD, and No Trauma History: A Comparative Study*

Researcher: Puja Maji

Contact Information: yes.puja01@gmail.com /8276812001

Principal Investigator: Puja Maji

Supervisor: Anindita Mukherjee

Introduction and Purpose of the Study:

You are invited to participate in a research study that aims to explore hypersexuality, sexual desire, and /exposure to or unresolved trauma. Specifically, the study seeks to investigate the influence of stressful life events/trauma and its effect on sexual behaviour.

The total time commitment is approximately 15 minutes.

Confidentiality and Privacy:

Your participation in this study will remain confidential. All data collected will be coded and stored securely. Any identifying information will be removed during the data analysis process. Only the research team will access your responses, and the results will be presented in aggregate form to protect your privacy.

Consent to Participate:

By signing below, you acknowledge that you have read and understood the information provided above and that you are voluntarily agreeing to participate in this study.

If you have any questions, feel free to ask the researcher or supervisor.

Participant Name: _____
Participant Signature: _____ **Date**: _____

Thank you for considering participation in this research study.

APPENDIX B

(Demographic Details)

Name Initials:

Age:

Gender

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ Other (Please specify): _____

Sexual Orientation

- ○ Heterosexual
- ○ Homosexual
- ○ Bisexual
- ○ Asexual
- ○ Queer
- ○ Other (Please specify): _____

Educational Level

- ○ Class 10
- ○ Class 12
- ○ Graduation degree
- ○ Master's degree
- ○ Master's degree and above

Employment Status

○ Employed full-time
○ Employed part-time
○ Self-employed
○ Unemployed
○ Retired
○ Student
○ Homemaker

Relationship Status

○ Single
○ In a relationship
○ Married
○ Separated

○ Divorced

Socioeconomic Status (SES)

○ Low income
○ Middle income
○ Upper-middle income
○ High income

Geographic Location

○ Urban
○ Suburban
○ Rural

Family Mental Health History

○ Yes ○
No
○ Don't know

Physical Illness (if any)

○ (Please specify): _____ **APPENDIX C**

International Trauma Questionnaire

Questionnaire 1:

Please read each item carefully, then circle one of the numbers to indicate how much you have been bothered by that problem.

P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P5. Being “super-alert”, watchful, or on guard?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P6. Feeling jumpy or easily startled?

1. Not at all

2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P7. Affected your relationships or social life?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P8. Affected your work or ability to work?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

Instructions: Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself, and ways you typically relate to others. Answer the following, thinking about how true each statement is of you.

C1. When I am upset, it takes me a long time to calm down.

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C2. I feel numb or emotionally shut down.

1. Not at all
2. A little bit
3. Moderately

4. Quite a bit
5. Extremely

C3. I feel like a failure.

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C4. I feel worthless.

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C5. I feel distant or cut off from people.

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C6. I find it hard to stay emotionally close to people.

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

In the past month, have the below problems in emotions, in beliefs about yourself, and in relationships:

C7. Created concern or distress about your relationships or social life?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C8. Affected your work or ability to work?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

C9. Affected any other important parts of your life such as parenting, or school or college work, or other important activities?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

APPENDIX D

This questionnaire asks about your sexual desire. By desire, we mean INTEREST IN or WISH FOR SEXUAL ACTIVITY. For each item, circle the number that best shows your thoughts and feelings:

1. During the last month, how often would you have liked to engage in sexual activity with a partner (for example, touching each other's genitals, giving or receiving oral stimulation, intercourse, etc.)?

0 = Not at all

1 = About once a month

2 = About once every two weeks

3 = About once a week

4 = Twice a week

5 = 3-4 times a week

6 = once a day

7 = More than once a day

2. During the last month, how often have you had sexual thoughts involving a partner?

0 = Not at all

1 = About once a month

2 = About once every two weeks

3 = About once a week

4 = Twice a week

5 = 3-4 times a week

6 = once a day

7 = More than once a day

3. When you have sexual thoughts, how strong is your desire to engage in sexual behavior with a partner?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

4. When you first see an attractive person, how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

5. When you spend time with an attractive person (for example, at work or school), how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

6. When you are in romantic situations (such as a candle-lit dinner, a walk on a beach, etc.), how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

7. How strong is your desire to engage in sexual activity with a partner?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

8. How important is it for you to fulfill your sexual desire through activity with a partner?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

9. Compared to other people of your age and sex, how would you rate your desire to behave sexually with a partner?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

10. During the last month, how often would you have liked to behave sexually by yourself? (for example, masturbating, touching your genitals, etc.)?

0 = Not at all

1 = About once a month

2 = About once every two weeks

3 = About once a week

4 = Twice a week

5 = 3-4 times a week

6 = once a day

7 = More than once a day

11. How strong is your desire to engage in sexual behavior by yourself?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

12. How important is it for you to fulfill your sexual desires to behave sexually by yourself?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

13. Compared to other people of your age and sex, how would you rate your desire to behave sexually by yourself?

0 1 2 3 4 5 6 7 8

No Desire Strong Desire

14. How long could you go comfortably without having sexual activity of some kind?

0) Forever

1) A year or two

2) Several months

3) A month

4) A few weeks

5) A week

6) A few days

7) One day

8) Less than one day

APPENDIX E

Below are a number of statements that describe various thoughts, feelings, and behaviors. As you answer each question, select the number that best describes you. You can only select one number per statement, and please be sure to answer every question.

For the purpose of this questionnaire, sex is defined as any activity or behavior that stimulates or arouses a person with the intent to produce an orgasm or sexual pleasure. Sexual behaviors may or may not involve a partner (e.g. self masturbation or solo-sex, using pornography, intercourse with a partner, oral sex, anal sex, etc.)

1. **I use sex to forget about the worries of daily life.**

   Never Rarely Sometimes Often Very Often

2. **Even though I promised myself I would not repeat a sexual behavior, I find myself returning to it over and over again.**

   Never Rarely Sometimes Often Very Often

3. **Doing something sexual helps me feel less lonely.**

Never Rarely Sometimes Often Very Often

4. **I engage in sexual activities that I know I will later regret.** Never Rarely

   Sometimes Often Very Often

5. **I sacrifice things I really want in life in order to be sexual.**

Never Rarely Sometimes Often Very Often

6. **I turn to sexual activities when I experience unpleasant feelings (e.g. frustration, sadness, anger)**

Never Rarely Sometimes Often Very Often

7. **My attempts to change my sexual behavior fail.**

Never Rarely Sometimes Often Very Often

8. **When I feel restless, I turn to sex in order to soothe myself.**

   Never Rarely Sometimes Often Very Often

9. **My sexual thoughts and fantasies distract me from accomplishing important tasks.**

Never Rarely Sometimes Often Very Often

10. I do things sexually that are against my values and beliefs.

Never Rarely Sometimes Often Very Often

11. Even though my sexual behavior is irresponsible or reckless, I find it difficult to stop.

Never Rarely Sometimes Often Very Often

12. I feel like my sexual behavior is taking me in a direction I don't want to go.

Never Rarely Sometimes Often Very Often

13. Doing something sexual helps me cope with stress.

Never Rarely Sometimes Often Very Often **14. My sexual behavior controls my life.**

Never Rarely Sometimes Often Very Often

15. My sexual cravings and desires feel stronger than my self-discipline.

Never Rarely Sometimes Often Very Often

16. Sex provides a way for me to deal with the emotional pain I feel.

Never Rarely Sometimes Often Very Often

17. Sexually, I behave in ways I think are wrong.

Never Rarely Sometimes Often Very Often

18. I use sex as a way to try and help myself deal with my problems.

Never Rarely Sometimes Often Very Often

19. My sexual activities interfere with aspects of my life, such as work or school. Never Rarely Sometimes Often Very Often